Lincolnshire COUNTY COUNCIL Working for a better future		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

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A Meeting of the Health Scrutiny Committee for Lincolnshire will be held on Wednesday, 16 February 2022 at 10.00 am in the Council Chamber, County Offices, Newland, Lincoln LN1 1YL

MEMBERS OF THE COMMITTEE

County Councillors: C S Macey (Chairman), L Wootten (Vice-Chairman), M G Allan, R J Cleaver, S R Parkin, T J N Smith, Dr M E Thompson and R Wootten

District Councillors: S Woodliffe (Boston Borough Council), B Bilton (City of Lincoln Council), Mrs S Harrison (East Lindsey District Council), Mrs L Hagues (North Kesteven District Council), G P Scalese (South Holland District Council), M A Whittington (South Kesteven District Council) and Mrs A White (West Lindsey District Council)

Healthwatch Lincolnshire: Dr B Wookey

AGENDA

Item	Title	Pages
5	**East Midlands Ambulance Service Update** *(To receive a report from the East Midlands Ambulance Service, which provides the Committee with an update on the various issues relating to the emergency ambulance service in Lincolnshire. Ben Holdaway, Director of Operations and Sue Cousland, Divisional Director for Lincolnshire will be in attendance for this item)*	To Follow
6	**NHS Continuing Healthcare** *(To receive a report from Lincolnshire Clinical Commissioning Group, which provides the Committee with an update on NHS Continuing Healthcare. Wendy Martin, Associate Director of Nursing and Quality will be in attendance for this item)*	To Follow
7	**Suicide Prevention in Lincolnshire** *(To receive a report from Lucy Gavens, Consultant in Public Health, Public Health Division, Lincolnshire County Council, which provides the Committee with information on recent suicides in Lincolnshire and the action being taken locally to reduce future suicide deaths)*	19 - 56
8	**United Lincolnshire Hospitals NHS Trust- Reconfiguration of Urology Services Update** *(To receive a report from United Lincolnshire Hospitals NHS Trust, which provides the Committee with an update of the implementation of the new model for urology in Lincolnshire's hospitals. Dr Colin Farquharson, Medical Director and Mr Andrew Simpson, Consultant Urologist will be in attendance for this item)*	57 - 72
9	**Health Scrutiny Committee for Lincolnshire - Work Programme** *(To receive a report from Simon Evans, Health Scrutiny Officer, which invites the Committee to consider and comment on its forthcoming work programme)*	73 - 76

Debbie Barnes OBE
Chief Executive
8 February 2022

Please note:

This meeting will be broadcast live on the internet and access can be sought by accessing Agenda for Health Scrutiny Committee for Lincolnshire on Wednesday, 16th February, 2022, 10.00 am (moderngov.co.uk)

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
19 JANUARY 2022

PRESENT: COUNCILLOR C S MACEY (CHAIRMAN)

Lincolnshire County Council

Councillors L Wootten (Vice-Chairman), M G Allan, R J Cleaver, S R Parkin, T J N Smith, Dr M E Thompson and R Wootten.

Lincolnshire District Councils

Councillors S Woodliffe (Boston Borough Council), B Bilton (City of Lincoln Council), Mrs S Harrison (East Lindsey District Council), Mrs L Hagues (North Kesteven District Council), G P Scalese (South Holland District Council), M A Whittington (South Kesteven District Council) and Mrs A White (West Lindsey District Council).

Healthwatch Lincolnshire

Dr B Wookey.

Also in attendance

Katrina Cope (Senior Democratic Services Officer) an Simon Evans (Health Scrutiny Officer).

The following representatives joined the meeting remotely, via Teams:

Nick Blake (Head of Transformation and Delivery (South Locality), Lincolnshire Clinical Commissioning Group), Samantha Francis (Information and Systems Manager), Theo Jarratt (Head of Quality and Information), Wendy Martin (Associate Director of Nursing & Quality, Lincolnshire Clinical Commissioning Group) and Professor Derek Ward (Director of Public Health).

County Councillor C Matthews (Executive Support Councillor NHS Liaison, Community Engagement, Registration and Coroners) attended the meeting as an observer.

58 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

The Committee was advised that Councillor M A Whittington (South Kesteven District Council) had replaced Councillor R Kayberry-Brown (South Kesteven District Council) on the Committee until further notice.

The Committee was advised that an apology had also been received from Councillor S Woolley (Executive Councillor for NHS Liaison, Community Engagement, Registration and Coroners).

59 DECLARATIONS OF MEMBERS' INTEREST

No declarations of members' interest were made at this stage of the proceedings.

60 MINUTES OF THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE MEETING HELD ON 15 DECEMBER 2021

RESOLVED

That the minutes of the Health Scrutiny Committee for Lincolnshire meeting held on 15 December 2021 be agreed and signed by the Chairman as a correct record.

61 CHAIRMAN'S ANNOUNCEMENTS

Further to the Chairman's announcements circulated with the agenda, the Chairman brought to the Committee's attention the supplementary announcements circulated on 18 January 2022. The supplementary announcements referred to:

- East Midlands Ambulance Service (EMAS) - Involvement of Military Personnel;
- Covid-19 Update;
- Healthwatch Lincolnshire Live Panel Event: Dental Services in Lincolnshire;
- Healthwatch Lincolnshire Survey: Lakeside Healthcare in Stamford; and
- Proposed Arrangements for the Director of Public Health in Greater Lincolnshire.

Some clarity was sought regarding the involvement of military personnel working with EMAS. It was highlighted that the Committee would be receiving an update from EMAS at its meeting 16 February 2022, and that this would be a more appropriate time for members of the Committee to raise specific questions in relation to this matter. It was however noted that it was not unusual for support to be provided in emergency situations.

Further information was also sought regarding paragraph D on page 14 of the report pack – Priority to Improve Responsiveness of Urgent and Emergency Care and Build Community Care Capacity. The Committee was advised that the summary provided in the report was an extract from a more comprehensive document, and that this document could be shared with the members of the Committee.

RESOLVED

That the supplementary Chairman's announcements circulated on 18 January 2022 and the Chairman's announcements as detailed on pages 13 – 16 of the report pack be received.

62 LAKESIDE MEDICAL PRACTICE, STAMFORD - LESSONS LEARNT REPORT

The Chairman invited the following presenters from Lincolnshire Clinical Commissioning Group: Wendy Martin, Associate Director of Nursing and Quality and Nick Blake, Head of Transformation and Delivery (South Locality), to remotely present the report, which advised the Committee on the outcome of the NHS Lincolnshire Clinical Commissioning Group's (CCG) Lessons Learnt Review in relation to the previous operation of Lakeside Healthcare General Practice at Stamford.

The report highlighted the five phases of the review; and provided a key summary of the outcome from the lessons learnt which were detailed in Appendix 1 to the report.

In conclusion, the Committee noted that the recommendations following the Lessons Learnt Review and report were being included within an ongoing review and reorganisation of the CCG's Primary Care Commissioning Team and associated CCG functions.

During consideration of the report, the Committee raised some of the following comments:

- Timetable for when the lessons learnt were likely to be implemented. The Committee was advised that an updated version of the progress made was being prepared. It was noted that some of the lessons learnt had already been completed; and that this information would be made available to the Committee. It was noted further that progress would be monitored by the CCG's Primary Care Commissioning Committee;
- Some concern was expressed as to what measures were in place to prevent the same happening again. The Committee noted that the CCG's Estates Working Group had put systems in place to mitigate the chance of the situation happening again. Details of the recommendations put in place were shown in Appendix A to the report;
- Support of NHS England and NHS Improvement. It was noted that CCG officers had been working with NHS England and NHS Improvement to better understand current break clauses within leases. It was noted further that the function of contracts from the NHS England Regional Team had been delegated to CCGs over time and that in 2020 there had been a Memorandum Understanding to this effect;
- How engagement with partners was measured. It was reported that there was a range of dashboards used, and that locality assurance meetings and countywide quality assurance meeting were being held. It was reported further that some of the dashboard metrics could be shared with the Committee;
- Further clarification was sought as to which primary care services Lakeside had or were planning to re-instate and whether the CCG had now received full clarification in respect of these services. Confirmation was given that that the core primary care services had been reinstated at the St Mary's premises, with the exception of diagnostic testing which was being carried out by the practice at the Sheepmarket surgery;
- How much progress had been made with regard to the recommendations. The Committee was advised that progress was going well, and that an updated version of

the timetable could be made available to members of the Committee to confirm the progress being made; and

- Confirmation was sought as to whether the Lincolnshire Integrated Care System (ICS), due to come into place in July 2022, would continue with the recommendations highlighted in the report. Reassurance was given that the ICS would be continuing with the recommendations.

RESOLVED

1. That the report presented be received and noted.

2. That the recommendations, as set out in Appendix 1 to the Lessons Learned report be endorsed and that an updated timetable showing progress made against the recommendations be made available to members of the Committee.

63 SUSTAINABILITY TRANSFORMATION PARTNERSHIP CLINICAL CARE PORTAL DATA SHARING - UPDATE

The Committee considered a report from Derek Ward, Director of Public Health, which provided the Committee with an update on Lincolnshire County Council's involvement and activity to date in the Sustainability Transformation Partnership Clinical Care Portal.

The Chairman invited Samantha Francis, Information and Systems Manager and Theo Jarratt, Head of Quality and Information, to remotely, present the item to the Committee.

The Committee noted that the Sustainability Transformation Partnership Clinical Care Portal enabled organisations to share their recorded patient data with other partners in health and social care, via an online patient record populated from multiple source systems. Details relating to Phase 1 – Health data viewable via Mosaic; and Phase 2 – Social care data viewable via Portal were shown on page 30 of the report pack.

It was highlighted that the anticipated benefits of integrating Mosaic and the Portal would provide a more holistic view of the service user, data would only have to be recorded once; the data would help inform social prescribing in health and care; the data would be up to date and would be standardised; delays would be reduced, currently caused by request for information sharing; duplication of effort would be reduced with the service user; and there would be increased security in data sharing, which was currently done via physical transfer of paper files, email and attachments, or verbal communication.

The Committee was advised that Phase 1 had been achieved ahead of the expected target; and that Phase 2 was still in the development and testing stage.

Appendix A to the report provided feedback from Adult Care and Community Wellbeing Practitioners using the Care Portal to review patient health records; and Appendix B provided weekly totals for February to December 2021 of the number of Mosaic user visits to the care portal.

In conclusion, the Committee noted that shared access to service user/patient data was of great benefit to the Council's frontline practitioners and managers, as it enabled users to have a more holistic view of the patient and more efficient information sharing. It was noted further that the various areas of development across the Portal programme would combine to create a hub for multi-agency case management, which would inform and improve health and care services.

During consideration of this item, some of the following points were raised:

- Some concern was expressed that the data being provided could be incomplete; and concern was also raised regarding the security of data being shared. It was highlighted that the care portal interfaced with other health development systems. The records involved were complete and checked to ensure that the records were only accessed by staff with the appropriate credentials, and when a patient record was accessed the name of the user was logged. Officers agreed to checking that all paper records were included. Reassurance was given that the necessary agreements and governance arrangements were in place and that advice on GDPR [General Data Protection Regulations] had been sought from the start of the project. The Committee noted that United Lincolnshire Hospitals NHS Trust managed access to the system; and that appropriate access was given to individual service users depending on their roles. Reassurance was also given as with any system, audits were completed to ensure user compliance and that there was constant vigilance to prevent external threats;
- Whether East Midlands Ambulance Service (EMAS) would have access to the portal. The Committee noted EMAS had shared some of their data in December 2021. Officers agreed to check with Sustainability Transformation Partnership (STP) as to whether EMAS staff would have access to the system;
- The Committee was advised that further clarification was needed with regard primary care data being mandatory;
- Whether North Lincolnshire and Goole Foundation Trust would be included in the list of next data sources to be developed/added. The Committee was advised that this trust was on the list as were other neighbouring trusts, as well as Lincolnshire Community Health Services NHS Trust and Lincolnshire Partnership NHS Foundation Trust. The Committee was also advised that neighbouring Trusts would have a similar system, as the regional structures had an awareness of the requirements of Local Health and Care Records across borders; and that a group had been set up to look at such matters. It was also highlighted that NHS Digital had stipulated that this was a national requirement across the country. It was noted that ultimately, it was the intention for Lincolnshire to connect regionally;
- Reassurance was given that training was given to new users joining the system;
- Use by Child Protection. It was confirmed that child protection had been one of the first services to be included. It was noted that the inclusion of primary care and the police was still work in progress.
- Private hospital care information would be picked up from local provider records;

- A request was made for a further update to be received in six months' time

The Chairman on behalf of the Committee extended his thanks to officers for their presentation.

RESOLVED

That the update on the Clinical Care Portal be received and noted and that a further update be received by the Committee in six months' time.

64 LINCOLNSHIRE ACUTE SERVICES REVIEW - FINALISATION OF THE COMMITTEE'S RESPONSE

The Chairman invited Simon Evans, Health Scrutiny Officer, to present the item, which invited the Committee to approve its final response to the consultation on the Lincolnshire Acute Services Review.

A copy of the draft response had been circulated to members of the Committee by email on 18 January 2022 and had been based on the views of the working group which had met on 6 January 2022.

Thanks were extended by local Grantham members to members of the Health Scrutiny Committee for Lincolnshire, Lincolnshire County Council, South Kesteven District Council, campaign groups, and the working group for their support regarding Grantham and District Hospital.

During consideration of the draft response, the Committee raised some of the following comments:

- Part B – The Need for Change, the Committee agreed there needed to be change, and had indicated with a tick as 'Strongly Agree' but the Committee was not completely convinced in three instances out of four that the proposals as detailed were right for the people of Lincolnshire. Following a short discussion, it was agreed that explanation paragraph would be included in the introduction on page to explain the Committees stance; and that an additional explanation box would be included on page two directly after the tick boxes;
- Acute Beds at Grantham and District Hospital – If budgets were to be held by the local authorities, as opposed to the NHS, the Committee would wish to see the County Council receiving adequate funding to ensure high quality service provision; and would not wish it to become a burden on the County Council's finances. That the Committee would wish to be made aware of any changes to community bed provision, as the initiative developed;
- Praise was extended to the Health Scrutiny Officer for the design and content of the response document; and

- Reference was also made to the poor attendance by members of the public at events, and consultation with hard-to-reach groups.

The Chairman extended his thanks to the Committee and to everyone involved in the Acute Service Review over the years.

RESOLVED

That the Committee's final response (as per the document circulated to the Committee on 18 January 2022) to the consultation on the Lincolnshire Acute Services Review be unanimously approved subject to the addition of the amendments highlighted above.

65 DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT

The Chairman invited Derek Ward, Director of Public Health, to remotely present the item, which presented to the Committee the Director of Public Health's Annual Report 2021, which focussed on the health of children and young people in Lincolnshire and the impact of Covid-19 on this population.

A copy of the Director of Public Health's Annual Report 2021 was attached at Appendix A to the report; and Appendix B provided the Committee with an update on the progress made on previous Director of Public Health Report Recommendations.

The Committee was advised of the effects of the Covid-19 pandemic on children and young people in the county; how services supporting children had tailored their support during the pandemic; and the areas that needed to be focussed on as the county moved into a protracted period of recovery from the pandemic.

It was highlighted that the three areas that had been identified to address the issues highlighted in the report were:

- By delivering services designed for children and young people, not adapted adult services;
- By focussing on physical activity, diet and nutrition, emotional and mental well-being; and
- By prioritising education, increasing opportunity, and tackling health and social disparities.

Reference was also made to the proportion of the Lincolnshire population aged 0 - 19 at district and county level; child health in Lincolnshire and the leading causes of morbidity (years with a disability) and mortality (years of life lost) in 0 - 5 and 15 - 19-year-olds; the differences in water fluoridation and child deprivation within Lincolnshire; and the impact of Covid-19 on education, early years, mental health and emotional wellbeing.

Councillor Mrs L Hagues left the meeting 12:25pm.

In conclusion, the Committee was advised that children and young people in Lincolnshire were a priority and to ensure them a better future, focus would be made on the three key areas highlighted, which would be delivered by the ten priorities and recommendations as set out in figure 13, on page 70 of the report pack.

During consideration of the report, the Committee raised some of the following issues:

- Some concern was raised that adult mental health service provision was still an area that needed further consideration. It was agreed that this would be discussed further to see what could be brought forward for the Committee to consider, as it was highlighted this was a cross cutting issue, which was/had recently been considered by the Adults and Community Wellbeing Scrutiny Committee, and the Children and Young People Scrutiny Committee often considered children and young people's mental health;
- That the report could have included further information about the importance of communities and voluntary organisations. There was recognition that more could have been covered;
- That the Schools and Education percentages on page 60 did not reflect the achievements made by schools and that more information was available on the website with regard to school achievements;
- Healthy weight. The Committee was advised that a Child's Weight Programme was currently being developed by the County Council and that this would help provide information on healthy eating for children and their families. There was recognition that more needed to be done educationally to highlight healthy foods and that a whole range of work was being done in this area;
- Deprivation and fluoridation. The Committee was advised that more needed to be done to recruit dentists into Lincolnshire. The Committee noted that the commissioning of dentistry was to be moved over to local Integrated Care Systems, which would mean there would be more of a direct role locally. It was noted further that to improve fluoridation across Lincolnshire, representation would have to be made to the Secretary of State, and that this would be considered once everyone involved had been fully informed. That a further report could be brought to the Committee in this regard; and
- How the ten priorities/recommendations would be taken forward and whether the NHS was required to make a response. Clarification was given that there was no statutory responsibility from the NHS in this regard, however, the information would be shared with NHS colleagues. The Committee was advised that a further report could be presented to the Committee to update them on the progress made on the ten priorities/recommendations.

The Chairman on behalf of the Committee extended his thanks to the Director of Public Health for his presentation.

RESOLVED

1. That the 2021 Annual Report from the Director of Public Health be received and noted.

2. That the actions being taken to address the issues and recommendations presented in previous Director of Public Health Annual reports be noted.

66 HUMBER ACUTE SERVICES PROGRAMME - COMMITTEE'S RESPONSE TO ENGAGEMENT

Consideration was given to a report from Simon Evans, Health Scrutiny Officer, which invited the Committee to approve the draft response by the Committee's working group to the engagement on the Humber Acute Services Programme.

Attached at Appendix A to the report was a copy of a draft letter on behalf of the Health Scrutiny Committee for Lincolnshire on the Humber Acute Services Programme for the Committee's consideration and approval.

During consideration of the response letter, a request was made for consideration to be given to include East Lindsey residents in the consultation to be included in the Committee's response. It was noted that this had been included in the submission.

RESOLVED

That the draft response letter on behalf of the Committee as detailed at Appendix A on the report to the Humber Acute Services Programme be approved.

67 HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE - WORK PROGRAMME

The Chairman invited Simon Evans, Health Scrutiny Officer, to present the report, which invited the Committee to consider and comment on its work programme as detailed on pages 84 – 86 of the report pack.

The Committee highlighted the following items for inclusion in the work programme:

- It was requested that the item on the Community Pain Management Scheme, scheduled for 16 March 2022, include reference to the broader impacts of the service;
- GP provision – the Committee was advised that an update was due to considered by the Committee on 13 April 2022;
- Nuclear Medicine – This item was currently on the items to be programmed list and would be brought forward for consideration when proposals for consultation were brought forward by United Lincolnshire Hospitals NHS Trust; and
- Staffing challenges in hospitals.

RESOLVED

That the work programme presented be received, subject to addition of the items raised in the meeting relating to updates on the Clinical Care Portal, mental health services and an update on the progress of the ten priorities/recommendations from the Director of Public Health Annual Report; and that the items listed above be considered.

The meeting closed at 1.12 pm.

Lincolnshire COUNTY COUNCIL Working for a better future		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
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Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**16 February 2022**
Subject:	**Chairman's Announcements**

1. Covid-19 Update

National Developments

Since the Committee's last meeting on 19 January 2022, the following main developments have been confirmed:

- From 19 January, the guidance encouraging people to work from home if they can was withdrawn
- From 20 January, face masks were no longer compulsory for secondary school pupils in school classrooms.
- From 27 January, face masks were no longer compulsory in indoor public spaces, including the communal areas of schools. However, the government suggests people continue to wear face masks in crowded and indoor spaces where people may come into contact with people they do not usually meet. The requirement for people to show their NHS Covid pass at certain venues and events was also withdrawn.
- On 31 January, it was announced that regulations making vaccines a condition of deployment for health and social care staff would be revoked, subject to public consultation and Parliamentary approval. The government also stated that it would work closely with Royal Colleges and professional regulators to strengthen guidance, and consult on updates to the Department of Health and Social Care's Code of Practice for regulated providers to strengthen the requirements in relation to COVID-19, which applies to all Care Quality Commission (CQC) registered providers of all health and social care in England.
- From 11 February, all testing requirements will be removed from all fully vaccinated travellers (both residents and visitors) arriving in the UK, but passenger locator forms would continue to be required.

Local Developments

It has been confirmed that by 31 December 2021 over 80% of the eligible Lincolnshire population had received a booster vaccination, which compares to the national average of 64%.

2. Non-Emergency Patient Transport

It has been reported in the local media that Thames Ambulance Services Ltd, the provider of non-emergency patient transport in Lincolnshire since July 2017, has launched legal challenges against Lincolnshire Clinical Commissioning Group on the procurement process for the new contract for this service, which is due to begin from 1 July 2022.

The media report refers to the two lots of the new contract, which are call handling and patient assessment; and the provision of the service, and an original award of these two lots to two separate providers. Subsequently, the preferred provider of the call handling and patient assessment element of the service withdrew on the basis that this element of the contract would be subsidised by the other element of the contract, where the preferred bidder is the East Midlands Ambulance Service NHS Trust. TASL is arguing that the procurement process should be re-run.

3. Availability of NHS Dental Appointments

On 25 January 2022, the government announced funding of £50 million to secure 350,000 more dental appointments before the end of this financial year. The intention is that people suffering from oral pain, disease, and infection will get treatment, as services return to pre-pandemic levels. The Midlands NHS region has been allocated £8.9 million from this sum.

The government has stated that children, people with learning disabilities, autism, or severe mental health problems, will be prioritised. Locally, NHS teams will use the funds to secure increased capacity amongst local dentists, who as part of this scheme will be paid more than a third on top of their normal fee for delivering this care outside of core hours, such as early morning and weekend work.

During the pandemic, the NHS has protected dentists' income when strict infection prevention control guidance meant dentists needed to operate at severely reduced capacity. Infection prevention control measures were significantly eased in November 2021 and since the start of this year the NHS has required dental practices to operate at 85% of their pre-pandemic contracted activity.

4. Healthwatch Lincolnshire Live Panel Event: Dental Services in Lincolnshire

At the Committee's last meeting, it was reported that Healthwatch Lincolnshire would be holding an online live panel event from 10 am to 11 am on 26 January 2022, to provide patients the opportunity to ask the questions that about their dental care in Lincolnshire.

Healthwatch Lincolnshire has announced that the event on 26 January could not proceed owing to the availability of panel members and has rescheduled the event for 30 March, again from 10 am until 11 am. Healthwatch has stated that it is grateful for the questions received, and information would be provided in response.

5. Volunteer Support for People in Mental Health Crisis

Lincolnshire Partnership NHS Foundation Trust (LPFT) has announced that as part of its work to support and improve the mental health crisis care offered in Lincolnshire, three new night light cafés in have been opened in Gainsborough, Grantham and Spalding. There are already ten night light cafes already open in Lincoln.

LPFT has explained that night light cafés are safe spaces that offer an out-of-hours, non-clinical support service and are staffed by teams of trained volunteers who are available to listen. Night light cafés can also provide signposting advice and information on other organisations that may be able to help with specific needs, such as debt advice or emergency food parcels. They can provide users with somewhere to go and something to do before they reach a mental health crisis, which helps reduce the requirement for public services involvement. People are asked to call or send a quick message to book in advance to make sure someone is available to listen and help at the café. Agencies or GPs can also refer individuals, with their consent, by completing an online referral form.

Night light cafés are funded by NHS England and NHS Improvement as an integral part of the Lincolnshire Mental Health Transformation Programme, which is committed to improving mental health and wellbeing by creating opportunities for people to thrive in connected communities.

The cafés are co-ordinated by Acts Trust in Lincoln (www.actstrust.org.uk) in partnership with other local charities who provide the venues around the county. On average, almost 29 guests a week visited a night light café during 2021 and during the pandemic Acts Trust made over 1,000 phone calls to people who needed support, or a friendly ear to listen to them. Night light cafés allow people to have better access to face-to-face help when they are struggling in an evening, when practices and community mental health teams are less readily available.

Acts Trust is now working in partnership with existing charities in Stamford, Bourne, and Long Sutton with venues also being sought in Skegness and Boston.

6. Mental Health Crisis Assessment Centre

Lincolnshire Partnership NHS Foundation Trust (LPFT) has also announced plans to open a new urgent assessment centre by the end of January, which would enable patients with a mental health related crisis to be taken directly to, or walk-in at, a dedicated centre in Lincoln, rather than going to A&E, as currently. This initiative will support the wider Lincolnshire health and care system in reducing demand in local emergency departments, as data show that around 70% of people attending A&E, with a mental health concern, do not have a physical health care need.

LPFT has also stated that sometimes A&E departments cannot always provide the calming, therapeutic environment for people in crisis, and Lincolnshire will be leading the way as one of just a handful of trusts nationally trialling this service. LPFT's aim is to enable people to access support and get the care they need at the point they need it.

7. Appointment of Interim Chair of the Lincolnshire Integrated Care Board

On 28 January 2022, the Lincolnshire Integrated Care System (ICS) announced that Sir Andrew Cash, OBE, had been appointed by NHS England as the Interim Chair of Lincolnshire's new NHS Integrated Care Board (ICB).

Lincolnshire ICS brings together local health and care organisations, local government, and voluntary and community organisations to improve the health and wellbeing of the population, tackle health inequalities, increase value for money for the taxpayer, and contribute more social and economic value in the county.

The proposed NHS Lincolnshire Integrated Care Board (ICB) will, subject to the passage of legislation through Parliament, be formally established on 1 July 2022 to oversee the commissioning, performance, financial management and transformation of the local NHS. It will also subsume the responsibilities of the NHS Lincolnshire Clinical Commissioning Group, which will close down on 30 June.

Sir Andrew Cash is currently the system lead for the South Yorkshire and Bassetlaw ICS. He is also deputy chair of the NHS Confederation, a membership body which represents NHS organisations across England. Prior to that, Sir Andrew Cash held several NHS chief executive and senior leadership roles in the NHS, and was most recently until 2018 the Chief Executive of the Sheffield Teaching Hospitals NHS Foundation Trust. Andrew has also served as Director General for Provider Development in the Department of Health.

8. Lincolnshire Health and Care Collaborative – Chief Executive

On 31 January 2022 it was announced that following a competitive recruitment process, Peter Noble had been appointed as Managing Director for the Lincolnshire Health and Care Collaborative, with effect from 1 April 2022.

Peter Noble has worked for Newcastle Health Innovation Partners, a large Academic Health Science Centre in the North East, where he has held the role of Chief Operating Officer. Prior to that Peter has worked for the Science and Technology Research Council, universities in both the UK and overseas, as well as a number of NHS organisations.

A provider collaborative is defined by NHS England and NHS Improvement as an entity focused on two or more NHS trusts or NHS foundations trusts. They can involve a range of partners and will become a requirement to support the new Integrated Care System arrangements. The Lincolnshire Health and Care Collaborative (LHCC) has evolved from a previous provider alliance comprising Lincolnshire Community Health Services NHS Trust, Lincolnshire Partnership NHS Foundation Trust, United Lincolnshire Hospitals NHS Trust and the Lincolnshire Primary Care Network Alliance. The LHCC has been developing its membership and now includes Lincolnshire County Council and the Lincolnshire Care Association.

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Open Report on behalf of Derek Ward, Director of Public Health

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**16 February 2022**
Subject:	**Suicide Prevention in Lincolnshire**

Summary:
The purpose of this report is to provide information on recent suicides in Lincolnshire and the action that we are taking locally to reduce future suicide deaths.

Suicide devastates families and communities. It is the biggest killer of men aged under 50 and all adults under the age of 35. Suicide is also the leading cause of death for 10-19 year olds.

A suicide death is often the result of the ultimate loss of hope and purpose in life. Whilst the relationship between suicide and mental ill health is well established, many suicides happen impulsively in moments of crisis with a breakdown in the ability to deal with life stresses, such as financial problems, relationship break-up or chronic pain and illness.

There are actions that we can take to prevent suicides. The Lincolnshire Suicide Prevention Strategy 2020 – 2023, developed by a multi-agency partnership, identifies five priorities to reduce suicides in Lincolnshire. These priorities, and key actions completed in 2021 and for delivery in 2022 our outlined in the report.

Actions Required:

Health Scrutiny Committee for Lincolnshire is asked to:

- receive this report on suicide prevention in Lincolnshire and to note its content.
- note the actions being taken to reduce suicide deaths.

1. Background

England and Wales

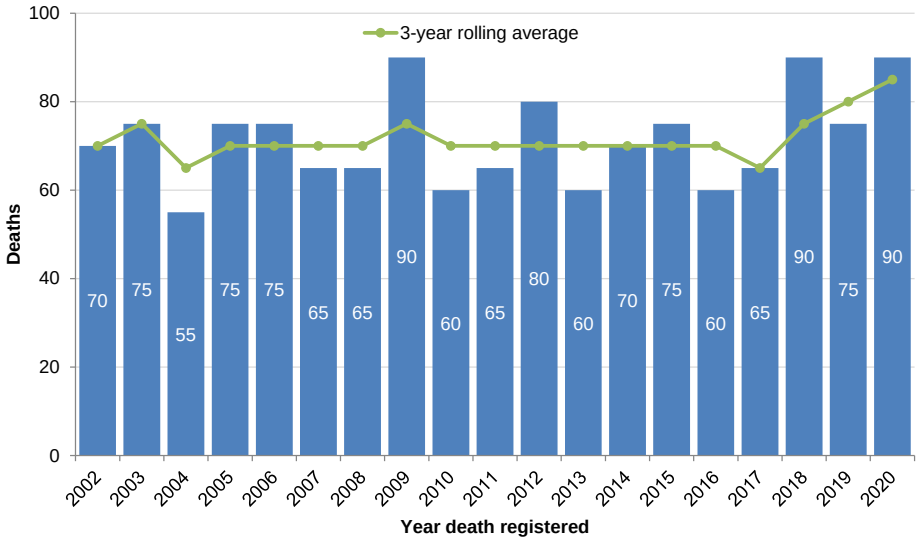
In 2020, there were 5,224 suicides registered in England and Wales. This is 10.0 per 100,000 people. Around three-quarters of registered suicide deaths in 2020 were for men (3,925 deaths; 75.1%), which follows a consistent trend back to the mid-1990s. The rates are highest among males and females aged 45-49 years old. There are regional variations with the lowest rate of suicide in London (7.0 deaths per 100,000) and highest in the North East (13.3 deaths per 100,000).

In England and Wales, the rate of death in 2020 was significantly lower than in 2019 (11.0 per 100,000), and this decrease is likely to be driven by a decrease in male suicides at the start of the coronavirus pandemic, and delays in death registrations because of the pandemic. In England and Wales, all deaths by suicide are certified by a coroner following an inquest and cannot be registered until the inquest is completed.

Lincolnshire

In Lincolnshire, in 2020 there were 90 deaths due to suicide and undetermined intent. Figure 1 shows the number of suicide deaths in Lincolnshire between 2002 and 2020.

Figure 1: Number of deaths (rounded for suppression) due to suicide in Lincolnshire, single year and three-year averages, 2002-2020



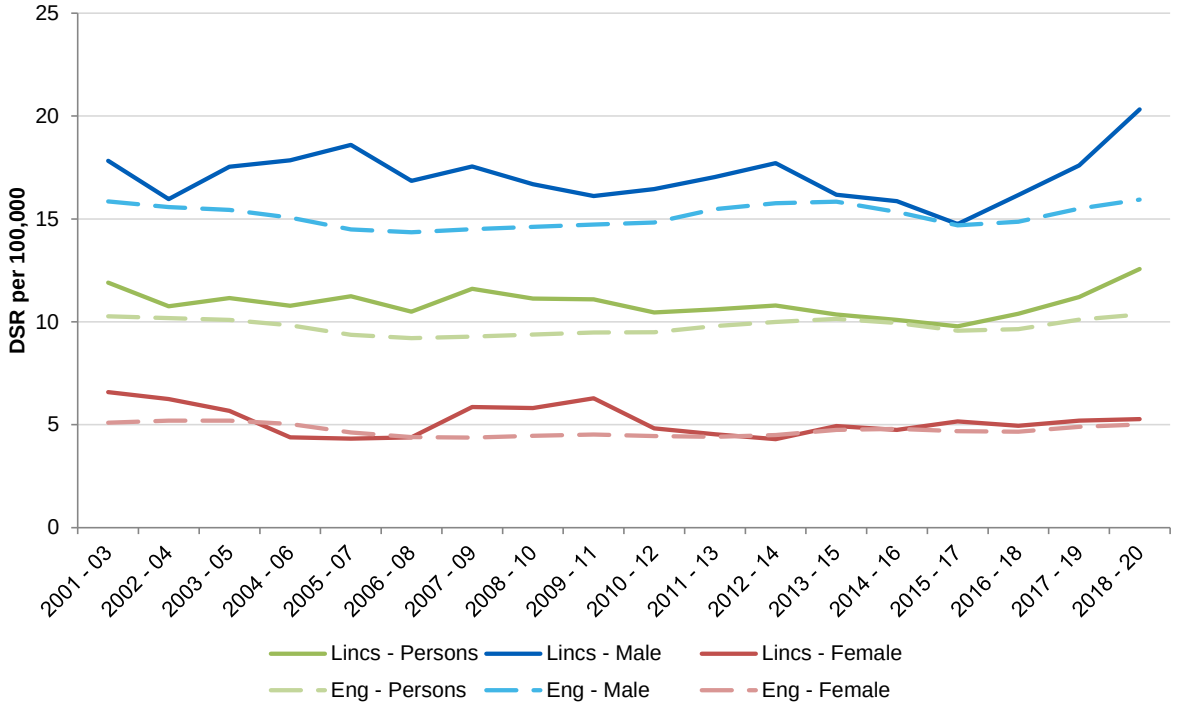
Source: NHS Digital, Civil Registration, Primary Care Mortality Database

Every suicide death is a tragedy, but due to the overall small number of suicide deaths each year there can be noticeable variation and so to investigate trends over time and to understand differences between demographic and geographical sub-groups, we pool data in rolling 3-year periods. In the latest period for which data is available (2018-2020) there were 255 suicide deaths in Lincolnshire (an average of 85 deaths a year). This is higher than in 2017-19 when there were 230 deaths in Lincolnshire (an average of 80 deaths a year).

Gender

Between 2018 and 2020 the male suicide rate in Lincolnshire was 20.3 per 100,000, which is significantly higher than the England average of 15.9 per 100,000. For females, the suicide rate was 5.3 per 100,000, comparable to the England rate of 5.0 per 100,000. Figure 2 shows the trend in male and female suicide rates over time. Since 2015-17 the suicide rate for all persons has increased, driven by rises in male suicides.

Figure 2: Directly standardised mortality rates due to suicide in Lincolnshire, by gender

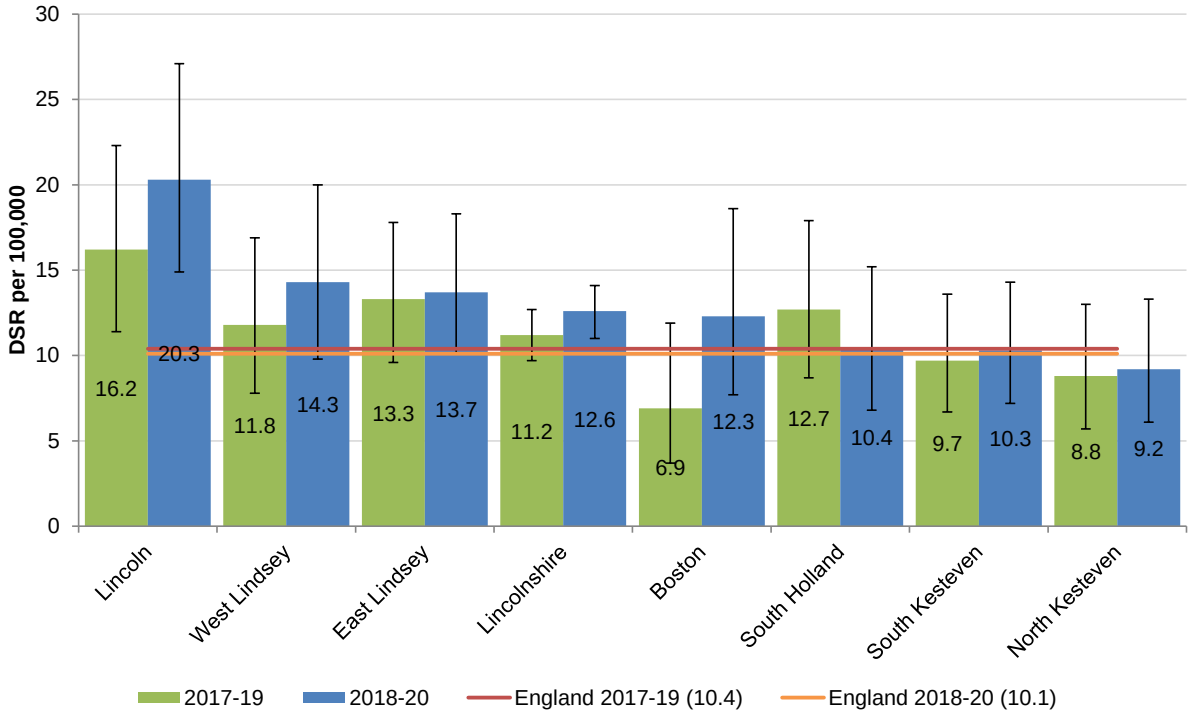


Source: ONS, Suicides in England and Wales 2020; NHS Digital, Civil Registration, Primary Care Mortality Database

Districts

There is variation in the suicide rate by district. In 2018-2020, Lincoln had the highest rate of 20.3 per 100,000. This was the highest rate in England. The rate in all other districts is comparable to the national average of 10.4 per 100,000 (see Figure 3). Lincoln has had the highest suicide rates in the county since 2010-12, with the exception of 2015-17 when rates were highest in East Lindsey.

Figure 3: Directly standardised mortality rates due to suicide in Lincolnshire, 2017-19 and 2018-20



Source: ONS, Suicides in England and Wales 2020

Each year, we produce a Suicide Audit for Lincolnshire, which provides further breakdown of the available data on suicide deaths by age, method and other factors. The latest audit for 2020 (published in October 2021) is available as Appendix A.

Risk Factors

There are several key factors that increase the risk of death by suicide. Males are significantly more likely to die by suicide than females. The rate of suicide varies by age over time; in 2018-2020 the age group with the highest rate was 30-35 years, and in 2017-19 it was people aged 50-54 years. However, suicides among under 25s have risen in recent years, especially among females.

Other key risk factors identified nationally include:

- Financial hardship
- Relationship breakdown
- Unemployment
- Living in areas of higher deprivation
- Caring responsibilities
- Domestic violence, child neglect or abuse
- For men, working in the lowest-skilled occupations

In Lincolnshire, we work with the Coroner's Office to better understand the lives of people who have died by suicide, including any risk factors and contact with organisations, services or professionals prior to death. This provides a richer local picture of the circumstances surrounding suicide deaths in Lincolnshire.

Data from 2016 to 2019 tells us that:

- 26% of suicides were among people aged 50-59 years, 83% of which were men
- 14% of people who died by suicide were born outside the UK (mainly in the EU)
- 51% were either employed or self-employed at the time of their death
- The most common method of suicide was hanging, strangulation or suffocation, used in 60% in suicides
- 70% of suicides occurred in the individual's own home
- 43% had known suicidal tendencies and 40% of those who died by suicide had made at least one previous attempt
- 67% of people who died were known to have experienced some form of mental ill health

Covid-19 and Suicide

There is considerable public and professional concern about the potential impact on suicide rates of the Covid-19 pandemic and the measures taken to contain it. Covid-19 may present new risk factors, or exacerbate existing trends and inequalities in risk factors for suicide.

Suicide rates in England were rising before the pandemic. The 2018 rate rose by 12% and the 2019 rate, reported in September 2020, showed a 5% rise. It is too early to know what the ultimate effect of the pandemic will be on suicide rates; however, suicide is preventable and so we are acting now to protect people's mental health in these uncertain times.

Preventing Suicide in Lincolnshire

National guidance recommends that every local authority completes a suicide audit (see Appendix A), develops a suicide prevention strategy (see Appendix B), and establishes a multi-agency group to coordinate action within the local area. The Lincolnshire Suicide Prevention Strategy 2020-2023 was produced through active engagement with local partnerships through the Suicide Prevention Steering Group (our local multi-agency suicide prevention group) using local data and intelligence and with reference to regional and national strategies.

The Lincolnshire Suicide Prevention Strategy identifies five 'Priorities for Action':

1. We will develop a **Local Suicide Prevention Core Offer**, to share help and support available to people touched by suicide (including suicidal ideation).

2. We will target additional support to **High Risk Groups**. We will develop our understanding of how best to prevent suicide in high risk groups through research, analysis and engagement with key stakeholders, leading to prevention initiatives to support those at greatest risk from suicide.

3. We will support **Children and Young People** (CYP) and their families. The key focus will be to promote and improve children and young people's emotional wellbeing and mental health through effective awareness and support to CYP and families from birth right through to adulthood, as well as improving access to support, creating mentally healthy schools and communities for CYP, targeting promotion and support for the most vulnerable and providing crisis support as required.

4. We will develop our **Knowledge and Intelligence**. A key source of intelligence that has informed this strategy are the annual suicide audits completed by colleagues in Public Health. This will continue to be strengthened with further intelligence to determine the focus of the Suicide Prevention Strategy and Action Plan.

5. We will **Raise Awareness and Improve Training**. We will agree a common approach to raising awareness of suicide and of identifying training needs. The Lincolnshire Core Suicide Prevention Offer will include guidance that professionals and the public can access to increase awareness of suicide, associate risks and what they can do to help prevent suicide.

The Strategy is delivered through the multi-agency Lincolnshire Suicide Prevention Steering Group, which is made up of representatives from across the statutory and community and voluntary sector and includes representatives with lived experience of suicide.

<u>Key Actions in 2020-21</u>

To support delivery against the Suicide Prevention Strategy the Suicide Prevention Steering Group has delivered the following in 2020-21 (this list is not exhaustive):

- Developed a visual guide to pathways of support for individual and professionals. The pathway for adults is in final testing and we are now developing a separate pathway for children and young people.
- Piloted a suicide bereavement support service (with The Tomorrow Project).
- Supported the establishment of a range of local projects to prevent suicide through the Community Suicide Prevention Innovation Fund (CSPIF).
- Worked in key high risk settings to implement local frameworks/plans for suicide and self-harm prevention (including HMP Lincoln and Lincolnshire Partnership NHS Foundation Trust).
- Developed and distributed of a wide range of resources to promote positive mental health of children and young people with a focus on support for parents/carers and professionals.
- Started a review of Healthy Minds Lincolnshire, CAMHS and other emotional and behavioural support (including mental health crisis and suicide prevention for CYP)
- Implemented a new assessment form for young people in Lincolnshire Secure Unit that self-harm or are suicidal
- Developed a new CPD bulletin created for partners bringing together training, awareness courses and online resources

Key Priorities for 2022

Building on the work in 2021, and expanding the programme to address identified local needs, in 2022 the Lincolnshire Suicide Prevention Steering Group will:

- Expand our collaboration around data and intelligence, including nationally (with a particular emphasis on accessing and responding to attempted suicide data)
- Develop a Lincolnshire response to potential suicide clusters
- Review our communications and awareness campaigns
- Enhance the offer around suicide bereavement support
- Strengthen support for children and young people in line with recommendations in the National Confidential Inquiry into Suicide by Children and Young People.
- Refresh the Lincolnshire training offer for mental health, including suicide prevention
- Better understand the impact of Covid-19 on inequalities in mental health and wellbeing, and suicide rates, and identify effective action to support mental health and wellbeing and prevent suicides.

2. Consultation

This is not a consultation item.

3. Conclusion

This report summarises recent suicide deaths in Lincolnshire and the local action that we are taking to prevent future deaths. The Health Scrutiny Committee is asked to note the contents.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Lincolnshire Suicide Audit 2020
Appendix B	Reaching Out and Saving Lives: Lincolnshire Suicide Prevention Strategy 2020-23

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Lucy Gavens, Consultant in Public Health, who can be contacted at lucy.gavens@lincolnshire.gov.uk.

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Lincolnshire Suicide Audit

2020

Lincolnshire COUNTY COUNCIL

Working for a better future

Foreword

Suicide is a major issue for society and a leading cause of years of life lost. It is the biggest killer of people under the age of 35 and the biggest killer of men under the age of 50. It is the leading cause of death in the UK for 10-19 year olds. These deaths are often the result of the ultimate loss of hope and meaning of purpose in life. Suicide can devastate families and leave a lasting impact on their own wellbeing. However, suicide is not always inevitable and is preventable.

The Suicide Prevention Strategy for England recommends that local authorities develop a Suicide Prevention Strategy and Action Plan. Lincolnshire County Council Public Health published the Lincolnshire Suicide Prevention Strategy 2020 – 2023, which has been developed on a multi-agency basis, their ambition is to reduce suicide and suicide behaviours in Lincolnshire to a minimum (Source: Lincolnshire Suicide Prevention Strategy 2020 – 2023).

This annual suicide audit will support the strategy through provision of appropriate and timely intelligence that helps identify cohorts of local people who are at high risk of suicide. This intelligence will enable local priority actions for preventing suicide to be considered and developed. The value of this audit is to provide insight into suicide within Lincolnshire, including trends and identifying any areas where services could or need to be focused.

Global and national context

Suicide is defined as the intentional taking of one's own life. Since the Suicide Act 1961, it has been written in law that the act of suicide is no longer a criminal offence, however Section 2(1) of the Act provides that it is an offence to assist another person to die by suicide (Source: Cambridge Core). Suicidal behaviour is most commonly regarded and responded to as a psychiatric emergency. Suicide is considered to be a major public health problem, but is recognised as preventable with timely, evidence based interventions. (Source: World Health Organisation)

In 2016 the World Health Organisation (WHO) estimated there were an estimated 793,000 suicide deaths worldwide. This indicates an annual global age-standardised suicide rate of 10.5 per 100,000 population. The UK age standardised suicide rates are similar to some other Western European countries (like Portugal or Germany) but overall lower than France and some Scandinavian countries.

The Five Year Forward View for Mental Health set out clear recommendations on suicide prevention and reduction and made a commitment to reduce suicides by 10% nationally by 2020/21. In 2018/19 local communities most affected by suicide were being given additional funding to develop suicide prevention and reduction schemes. This investment marked the start of a three year programme worth £25 million that will reach the whole country by 2021.

At the time of writing, the NHS has made a renewed commitment that funding for mental health services will grow faster than the overall NHS budget, creating a new ring-fenced local investment fund worth at least £2.3 billion a year by 2023/24.

Suicide prevention features in the NHS Long Term Plan, and will include a dedicated quality improvement programme to implement the findings from the National Confidential Inquiry into Suicide and Safety in Mental Health in addition to multi-agency suicide prevention plans.

National suicide statistics

In 2019, the Office for National Statistics (ONS) reported there were 5,691 registered suicides in England and Wales, which equates to an age standardised rate of 11.0 deaths per 100,000. Suicides in England and Wales have remained consistent with the rate observed in 2018 of 10.5 deaths per 100,000 (5,420 registered suicides).

In line with recent trends, three quarters of registered suicides were among men. In 2019, 4,303 men died as a result of suicide, which equates to 16.9 deaths per 100,000, rising from 16.2 deaths per 100,000 in 2018. In comparison, the suicide rate for women in 2019 was 5.3 deaths per 100,000, a rise from 5.0 deaths per 100,000 in 2018.

In 2019, men aged 45 to 49 years had the highest suicide rates at 27.1 per 100,000 men, while women aged 50-54 years had the highest suicide rates at 7.4 deaths per 100,000. Suicides among under 25s have generally increased in recent years, most noticeably among females aged 10-24 years where the rate of 3.1 per 100,000 is at its highest level since 2012.

As reported in previous years, hanging, suffocation or strangulation remains the most common method for both men and women to take their own lives. In 2019, this accounted for 61.7% of suicides among men and 46.7% among women. The percentage of suicides by hanging among men has seen an upward trend from 44.5% of suicides in 2001 to 61.7% in 2019. Poisoning is the second most common method of suicide but is more common among women (36.2% of all suicides) than men (17.9% of all deaths). (Source: ONS, Suicides in England and Wales, 2019)

Risk factors

There is an apparent link to the socioeconomic factors and types of occupations of individuals:

- Relationship breakdowns contribute to suicide risk, the greatest risk is among divorced men, who in 2015 were almost three times more likely to end their lives than men who were married or in a civil partnership.
- People who live in more deprived areas where there is less access to services, employment and education are more at risk of suicide; i.e. people among the most deprived 10% of society, are more than twice as likely to die from suicide than the least deprived 10% of society. (Source: ONS, Who is most at risk of suicide?)
- The lowest risk of suicide was found among corporate managers and directors, professionals including health professionals, and people working in customer service and sales.
- Men working in the lowest-skilled occupations had a 44% higher risk of suicide than the male national average. The risk of suicide among low-skilled male labourers, particularly those working in construction roles, was 3 times higher than the male national average.

- The risk among men in skilled trades was 35% higher than national average. The risk was especially high among building finishing trades; particularly plasterers and painters and decorators who had more than double the risk of suicide than the male national average.
- The risk of suicide was elevated for those in culture, media and sport occupations for men (20% higher than the male average) and women (69% higher).
- For women, the risk of suicide among health professionals was 24% higher than the female national average; this is largely explained by high suicide risk among female nurses.
- Male and female carers had a risk of suicide that was almost twice the national average. (Source: ONS, Suicides by occupation)

Findings from registered mortality data for Lincolnshire

Methodology

The number of deaths from suicide and injury of undetermined intent in Lincolnshire was obtained from ONS's published data using the ICD10 codes X60-X84 (age 10+ only), Y10-Y34 (ages 15+ only) registered in the respective calendar years.

Civil Registration mortality data was used to provide both the numbers and age specific mortality rates (ASR) of deaths from suicide and injury of undetermined intent in Lincolnshire, as well as to provide additional context around demographics, methods of suicide and deprivation.

Where applicable, figures for deaths from suicide are presented as directly standardised rates (DSR) per 100,000 of the resident population. This method uses a standard age-specific population profile to enable a comparison of rates over time or between different geographical areas. The latest DSRs covering deaths between 2002 and 2020 for Lincolnshire, its districts and England have been obtained from ONS Suicides in England and Wales 2020.

Please note that in accordance with ONS disclosure rules surrounding mortality data, any counts where the number of deaths are less than 7 have been suppressed and any counts greater than 7 are reported to the nearest 5, to minimise the risk of unlawful disclosure due to small numbers.

Key findings

- There were 75 registered deaths in 2019 and 90 deaths in 2020 due to suicide and undetermined intent in Lincolnshire.
- Death from suicides among women decreased from 18 in 2018 to 9 in 2019. However in 2020 the number increased to 23. Deaths among men from suicide fell from 63 in 2018 to 55 in 2019, but again increased to 61 in 2020. Men made up 86% of all deaths from suicide in Lincolnshire in 2019 and 73% of all suicides in 2020.
- There were 230 deaths from suicide in Lincolnshire between 2017 and 2019, and 255 between 2018 and 2020.

- During 2017-19, suicide rates were highest in Lincoln (16.2 per 100,000) and East Lindsey (13.3 per 100,000); while in 2018-20, rates were highest in Lincoln (20.3 per 100,000) and West Lindsey (14.3 per 100,000).
- Between 2016-18 and 2018-20, suicide rates have increased across a number of districts, with the highest increases seen in Lincoln, which has risen by 34.4% (15.1 per 100,000 in 2016-18, 20.3 per 100,000 in 2018-20) and is the local authority with the highest suicide rate in England.
- Between 2017 and 2019, suicide rates were highest among those aged 50-54 years (17 per 100,000), which is consistent with national suicide rates. Between 2018 and 2020, the highest rates were among the 30-34 year age group, at 17.3 per 100,000.
- In 2017-19, men were 3.4 times more likely to die from suicide than women, and 3.9 times more likely in 2018-20.
- Hanging/strangulation is the most common method of suicide in Lincolnshire, making up 57.7% of all suicides between 2017 and 2019, and 71% between 2018 and 2020.
- Over the three year period between 2017 and 2019, the suicide rate in the most deprived decile (13.5 per 100,000) is 2.5 times as high as in the least deprived decile (5.3 per 100,000). Between 2018 and 2020, the suicide rate in the most deprived decile (18.9 per 100,000) is 3.1 times higher than the least deprived decile (6.0 per 100,000), and more than double the national rate of 9.3 per 100,000.

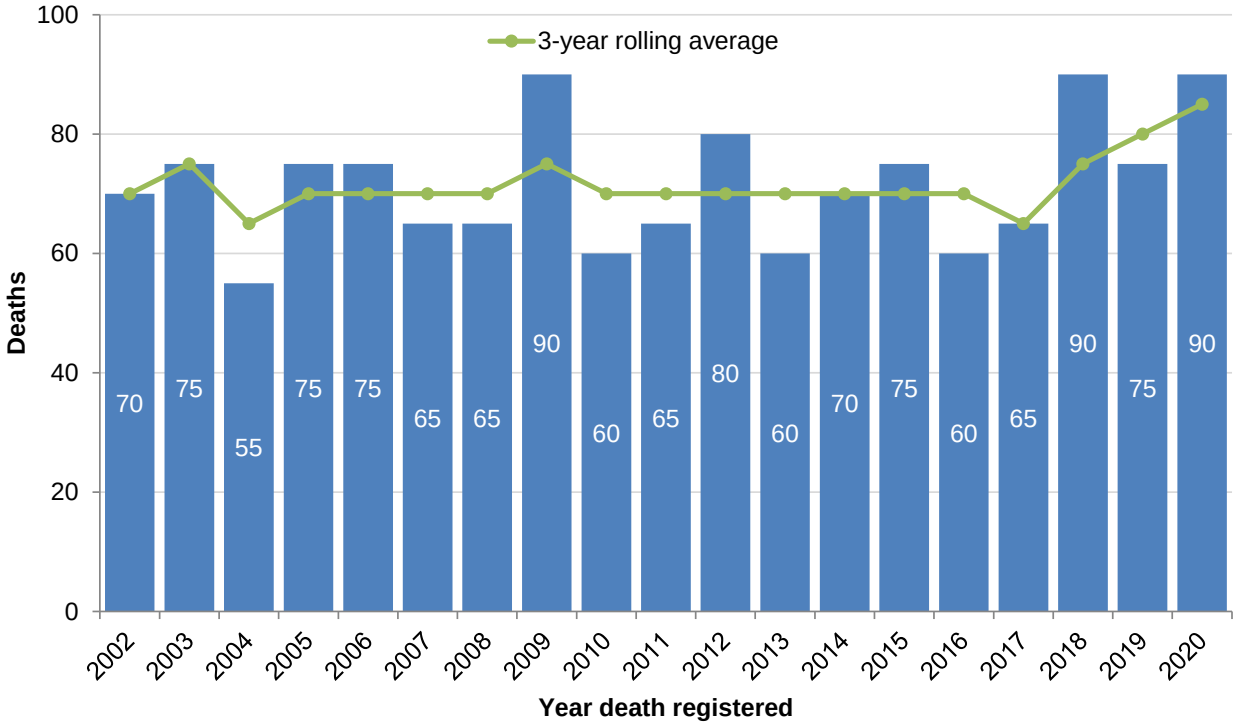
Suicide patterns over time

During 2019, there were 75 deaths due to suicide and injury of undetermined intent in Lincolnshire, which marks a 17% reduction on the 90 deaths seen in 2018. In 2020, the number increased to 90 deaths.

Due to the small numbers there can be noticeable variation year on year. Therefore, three year rolling averages have been used to smooth this variation and to investigate the longer term trend, as shown in Figure 1. Over the 3 year pooled period between 2017 and 2019, there were a total of 230 deaths (yearly average of 80 deaths), and between 2018 and 2020, there were a total of 255 deaths (yearly average of 85 deaths).

Please note that due to availability of data at the time of writing, other analysis in this report may differ from Figures 1 and 5.

Figure 1: Number of deaths (rounded for suppression) due to suicide in Lincolnshire, single year and three year averages, 2002-2020



Source: NHS Digital, Civil Registration, Primary Care Mortality Database

Figure 2: Number of deaths (rounded for suppression) due to suicide in Lincolnshire, by broad age group and district: 2018-2020

District	Broad age group			
	15-29	30-49	50-69	70+
Boston	*	10	*	*
East Lindsey	*	15	20	10
Lincoln	10	20	15	*
North Kesteven	*	10	10	*
South Holland	*	10	*	*
South Kesteven	10	10	10	*
West Lindsey	*	10	10	*

** Value suppressed as count is less than 7*

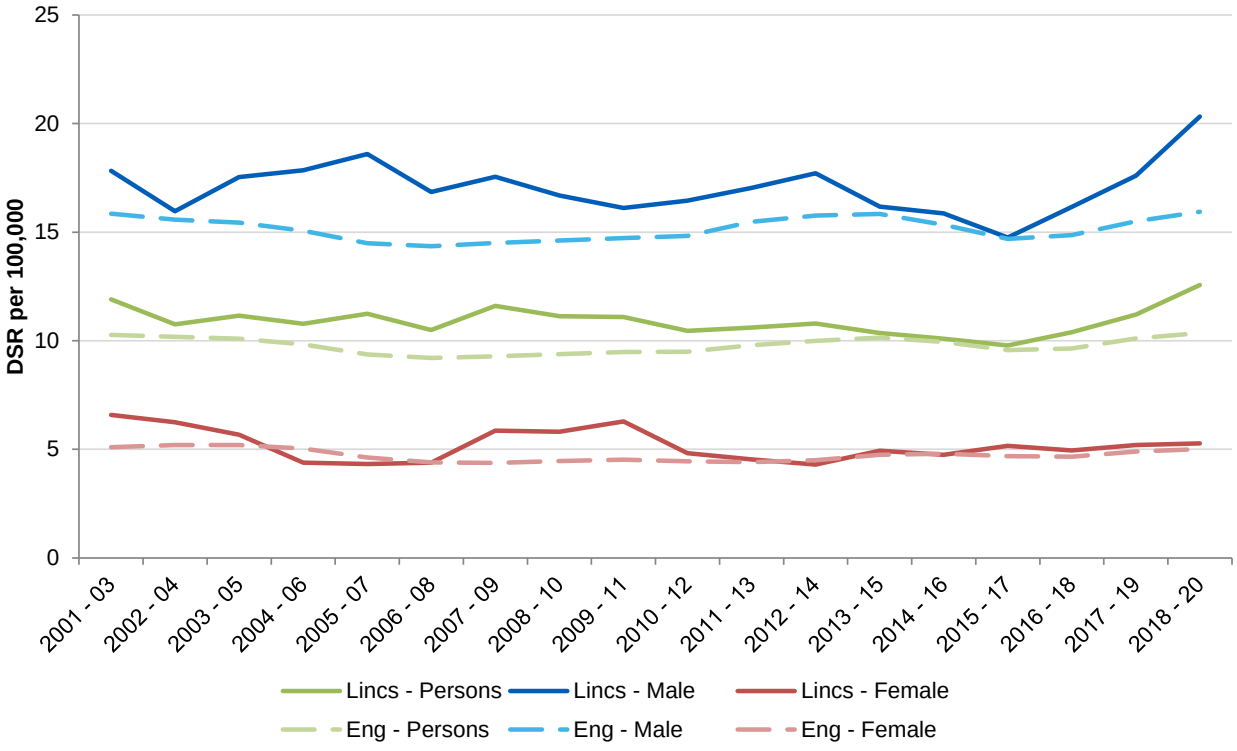
Figure 3: Number of deaths (rounded for suppression) due to suicide in Lincolnshire, by sex and age group: 2018-2020

Age group	Males	Females
15-19	*	*
20-29	25	*
30-39	30	10
40-49	30	10
50-59	40	10
60-69	20	*
70-79	15	*
80+	10	*

** Value suppressed as count is less than 7*

Figure 4 shows that between 2017 and 2019, total suicide rates (11.2 per 100,000), male suicide rates (17.6 per 100,000) and female rates (5.2 per 100,000) in Lincolnshire are statistically comparable to England rates (total 10.1 per 100,000, males 15.5 per 100,000, females 4.9 per 100,000). Between 2018 and 2020, total suicide rates (12.6 per 100,000) and male suicide rates (20.3 per 100,000) in Lincolnshire have increased from the previous period and are statistically significantly worse (higher) than England rates (total 10.4 per 100,000, males 15.9 per 100,000). Female suicide rates in Lincolnshire (5.3 per 100,000) have remained comparable to rates in 2017-19 (5.2 per 100,000) and the England rate of 5.0 per 100,000.

Figure 4: Directly standardised mortality rates (DSR) due to suicide in Lincolnshire, by gender



Source: ONS, Suicides in England and Wales 2020; NHS Digital, Civil Registration, Primary Care Mortality Database

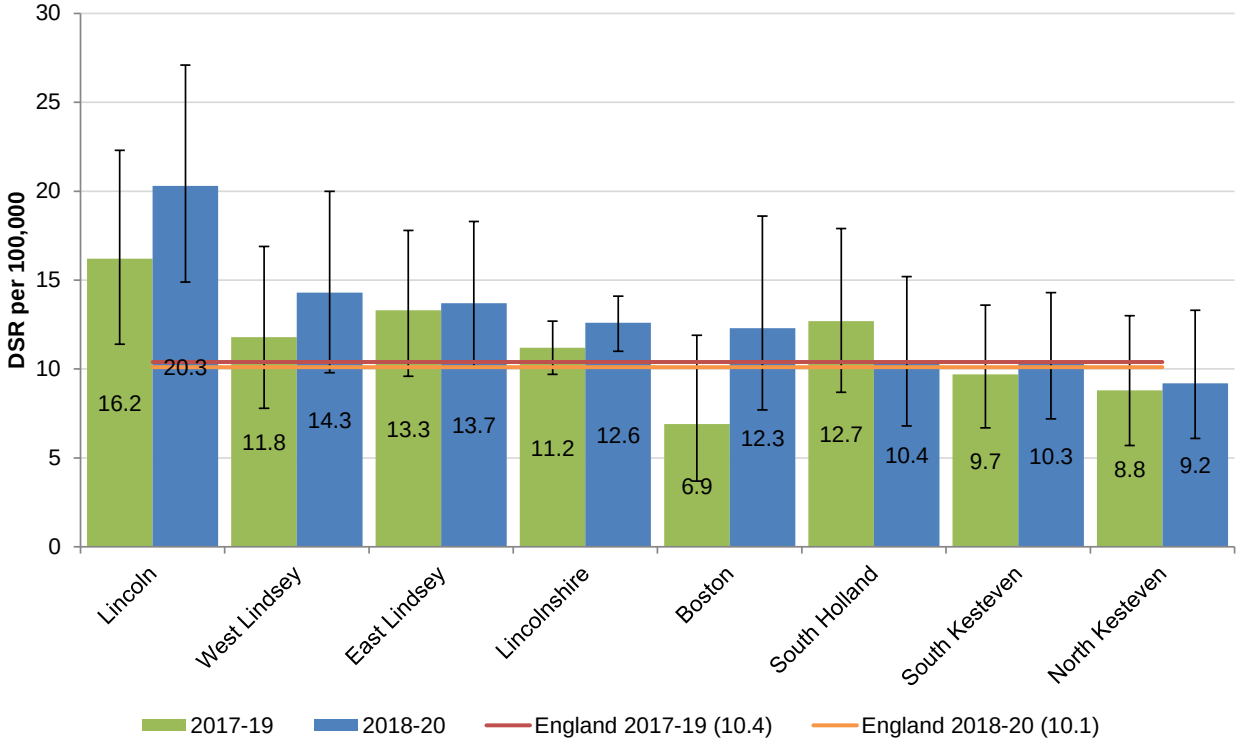
Longer term observations highlight that current rates are lower than in the 2000s, however male rates are increasing and almost at the highest suicide rates seen between 2005 and 2007 of 18.6 per 100,000. Total suicide rates have also increased and are close to the highest rates seen between 2001 and 2003 of 11.9 per 100,000. Female suicide rates have seen a much smaller increase and have remained fairly constant since 2013.

Due to the increase in male suicides between 2017 and 2019, the gender gap has widened on the previous period (2016-18), with 86% of suicides being males, however this gap has since narrowed to 73% between 2018 and 2020. Trend data shows that year on year, men make up between 63% and 86% of all suicides in Lincolnshire, suggesting some variation. It is important to note however that low numbers are very susceptible to random fluctuation year on year due to individual circumstances rather than whole population change.

Suicide patterns by geography

As seen in Figure 5, within Lincolnshire there is variation in suicide rates by district. In the latest periods, Lincoln has the highest suicide rate (16.2 per 100,000 in 2017-19, 16.1 per 100,000 in 2018-20). Between 2017-19 and 2018-20, rates have increased in most districts, except for South Holland, although these changes are not statistically significant. Lincoln has had the highest suicide rates in the county since 2010-12, with the exception of 2015-17 where rates were highest in East Lindsey.

Figure 5: Directly standardised mortality rates due to suicide in Lincolnshire, 2017-19 and 2018-20



Source: ONS, Suicides in England and Wales 2020

Further granular analysis of mortality data reveals that, there are seven electoral wards in Lincolnshire with five or more registered deaths from suicide. Four of these wards are in Lincoln,

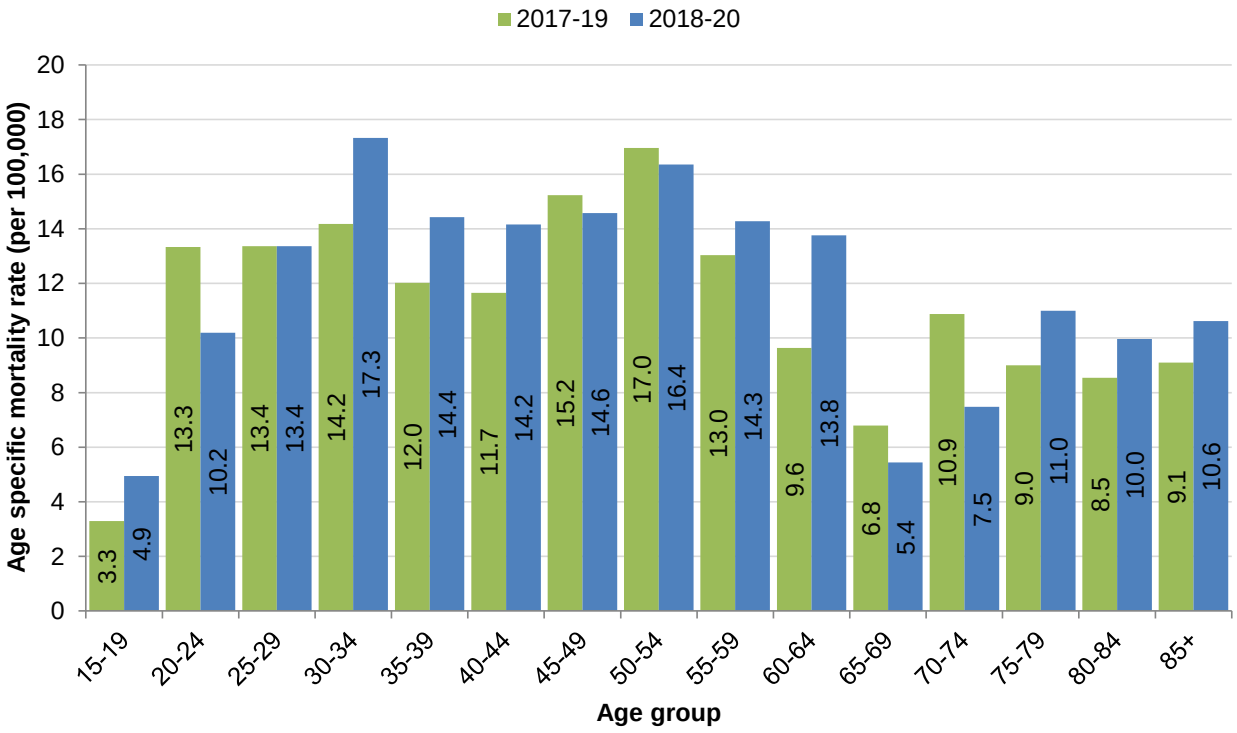
and one ward in East Lindsey, North Kesteven and West Lindsey. It should be noted that this analysis is based on the home postcode of the deceased, rather than the place of death.

Suicide patterns by age and gender

As highlighted in Figure 4, we know that deaths from suicide or undetermined intent are more common in men than women. This is a pattern seen nationally where three-quarters of registered suicides in 2018 were among men, which has been the case since the mid-1990s.

Figure 6 shows the age specific mortality rates for all suicides in Lincolnshire. The highest suicide rates in 2017-19 can be seen among the 50-54 year old age group, at 17.0 per 100,000, while in 2018-20, the highest rates were among the 30-34 year age group, at 17.3 per 100,000. The 15-19 year age group had the lowest rates in both 2017-19 (3.3 per 100,000) and 2018-20 (4.9 per 100,000).

Figure 6: Age specific mortality rates due to suicide in Lincolnshire, by quinary age group, 2017-19 and 2018-20



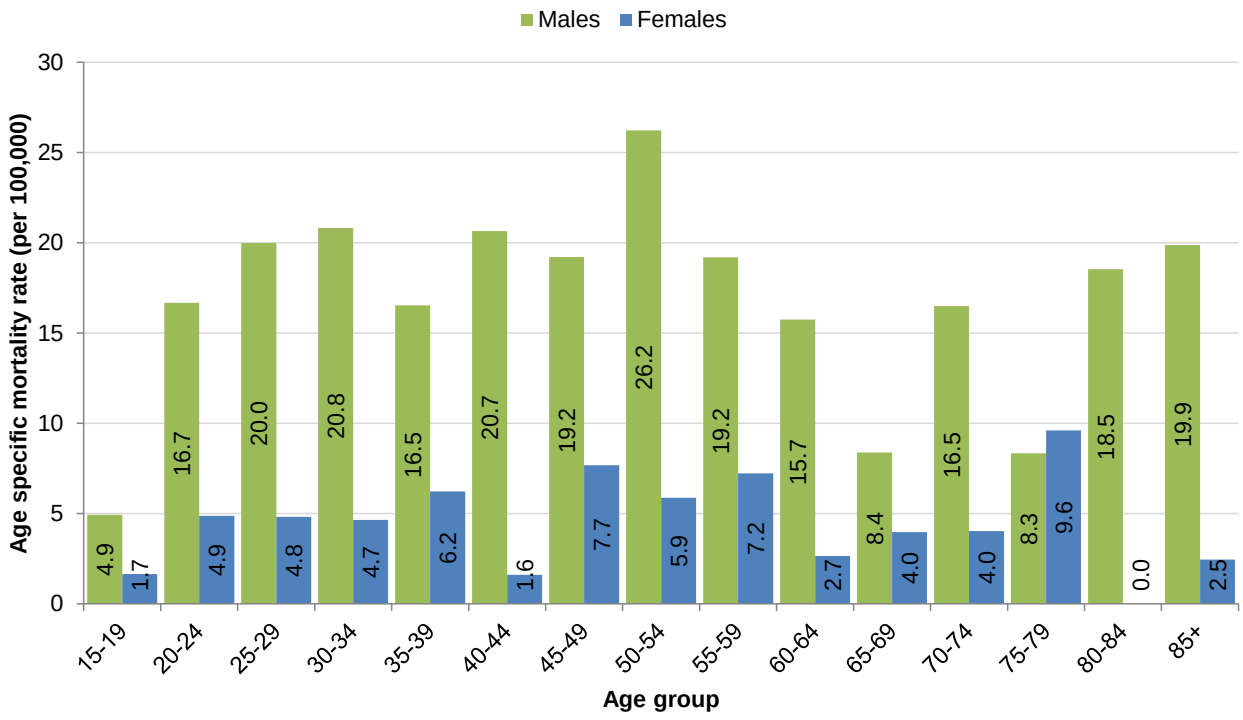
Source: NHS Digital, Civil Registration, Primary Care Mortality Database

Total suicide rates have seen the greatest increase in the 60-64 year age group (from 9.6 per 100,000 in 2017-19 to 13.8 per 100,000 in 2018-20), while rates among 20-24 year olds have fallen from 13.3 per 100,000 to 10.2 per 100,000. The largest increase in male suicide rates are among the 60-64 year age group (from 15.7 per 100,000 in 2017-19 to 24.3 per 100,000 in 2018-20), and the largest increase in female suicide rates are among the 40-44 year age group (from 1.6 per 100,000 in 2017-19 to 4.8 per 100,000 in 2018-20). It should be noted that these observed fluctuations could be a result of the low numbers seen in Lincolnshire, rather than an emerging change in deaths within specific age groups.

Figures 7 and 8 highlight the differences in age profiles between men and women who died from suicide. In 2017-19, men in this period were 3.4 times more likely to die from suicide than women, and 3.9 times more likely in 2018-20. For men, suicide rates are highest among those aged 50-54 years (26.2 per 100,000 in 2017-19, 27.5 per 100,000 in 2018-20), which differs to the national picture where men aged 45-49 have the highest suicide rates.

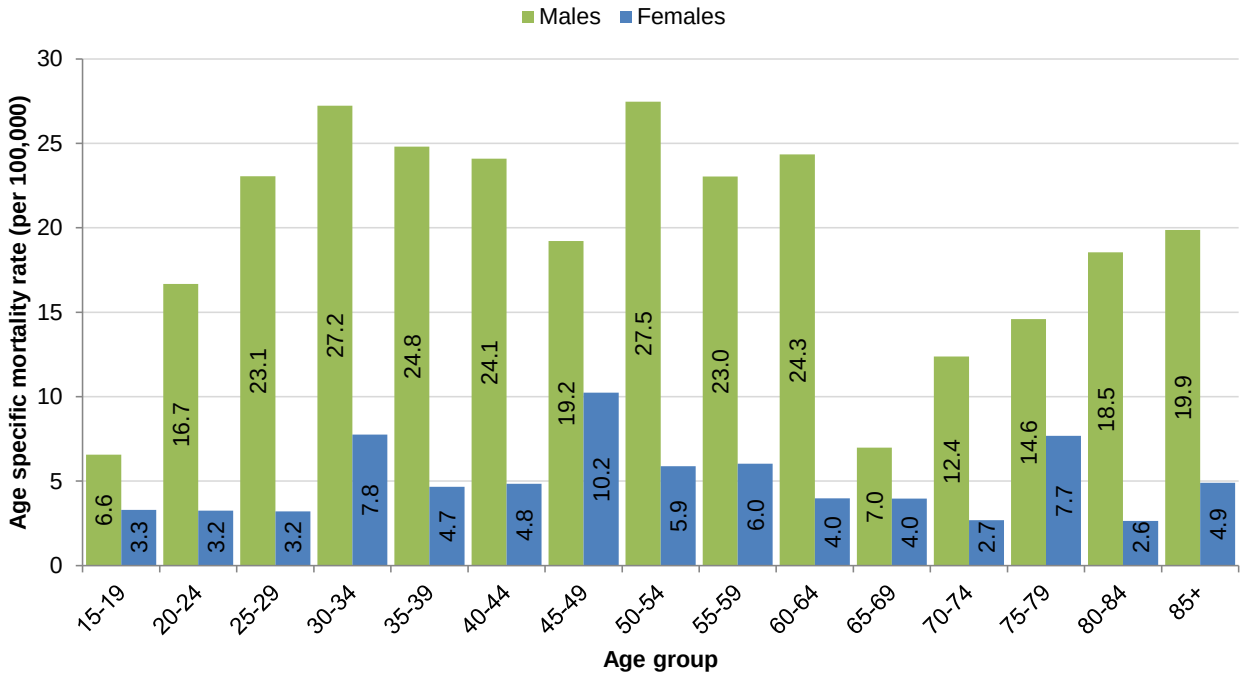
In addition to Civil Registration mortality data, the Adult Psychiatric Morbidity Survey (APMS) provides data on the prevalence of both treated and untreated psychiatric disorders in the English adult population (aged 16 and over). The 2014 survey found that 20.6% of adults had thought of taking their own life at some point, with women being more likely (22.4%) than men (18.7%) to have suicidal thoughts; while men are more likely to die from suicide, women are more likely to report an attempted suicide (8%) than men (5.4%). Almost half of those who reported an attempted suicide did not seek any help following their last suicide attempt.

Figure 7: Age specific mortality rates due to suicide in Lincolnshire, by sex and quinary age group, 2017-19



Source: NHS Digital, Civil Registration, Primary Care Mortality Database

Figure 8: Age specific mortality rates due to suicide in Lincolnshire, by sex and quinary age group, 2018-20



Source: NHS Digital, Civil Registration, Primary Care Mortality Database

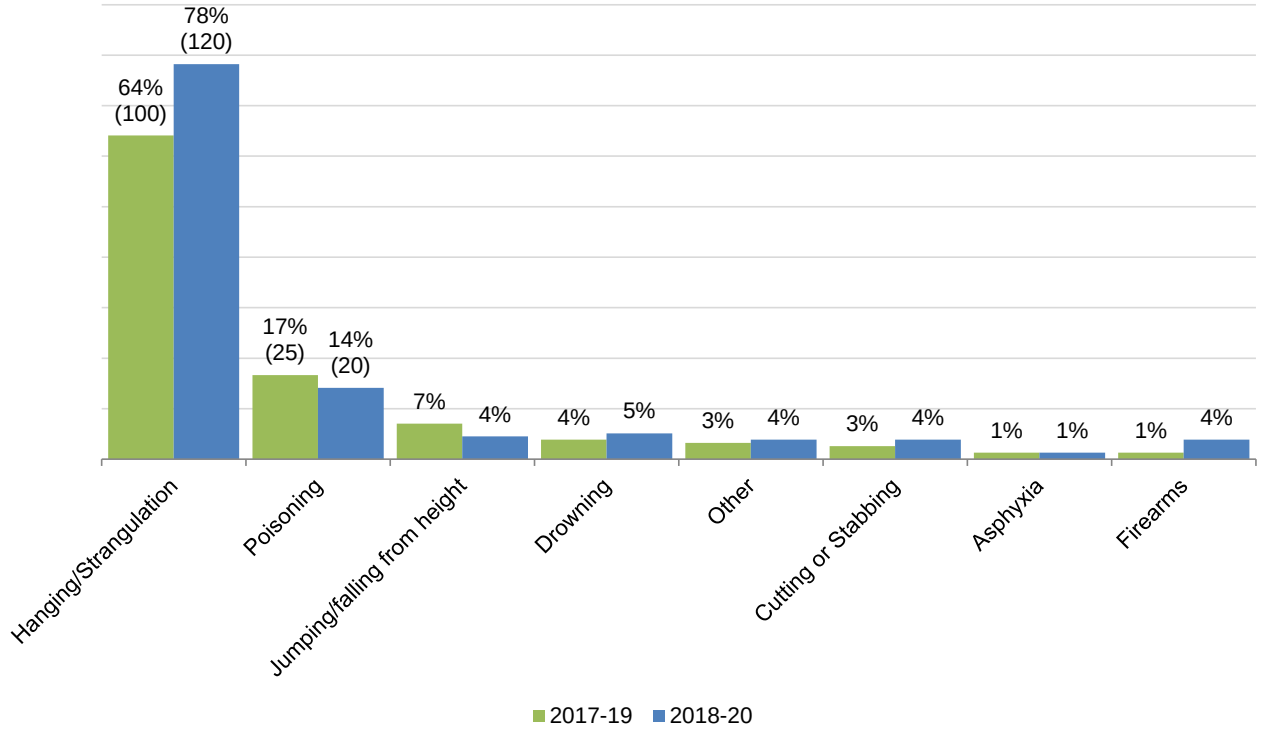
Suicide methods

In Lincolnshire, hanging/strangulation/suffocation is the most common method of suicide, making up 58% of all suicides in 2017-19 and 71% of all deaths in 2018-20. Patterns of suicides from hanging/strangulation have seen an upward trend, increasing from 41% of all deaths from suicide in 2001-03 to 62.4% in 2018-20, while suicides from poisoning have seen a downward trend from 33% of all deaths from suicide in 2001-03 to 17.5% in 2018-20.

Between 2018 and 2020, hanging/strangulation/suffocation continues to be the most common method among men (120 deaths from suicide or 78% of all suicides). The number of hanging/strangulation suicides among men has increased by 87% between 2001-03 and 2018-20.

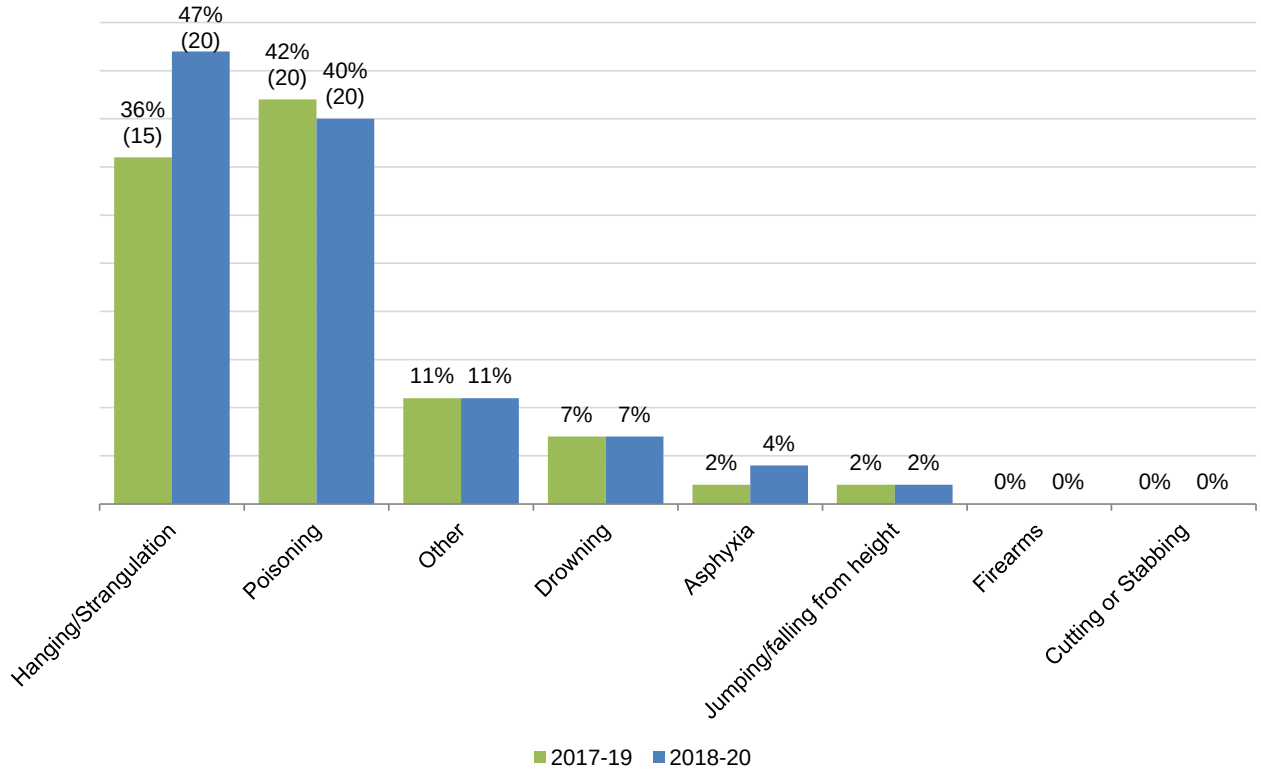
Poisoning was the most common method in female suicides in both 2016-18 (46%) and 2017-19 (42%); however, proportions of female suicides by poisoning have fallen by 37% between 2001-03 and 2018-20.

Figure 9: Male deaths due to suicide (rounded for suppression) in Lincolnshire, by method, 2017-19 and 2018-20



Source: NHS Digital, Civil Registration, Primary Care Mortality Database

Figure 10: Female deaths due to suicide (rounded for suppression) in Lincolnshire, by method, 2017-19 and 2018-20



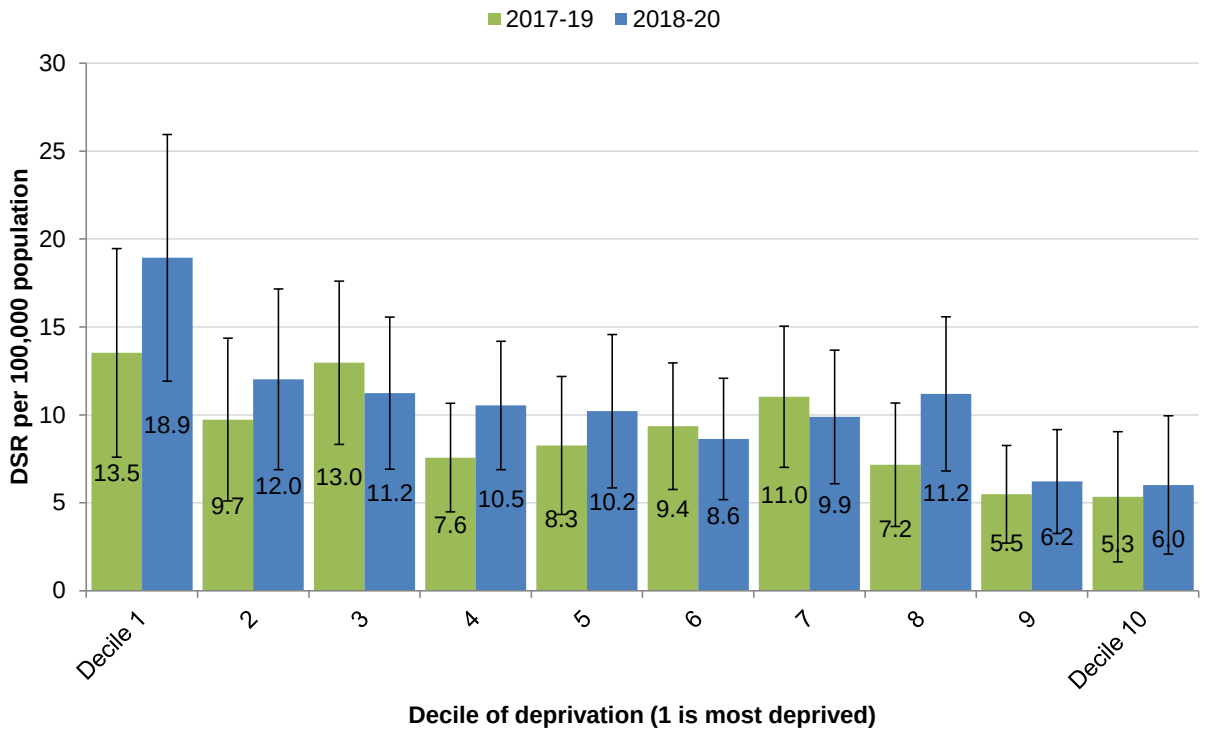
Source: NHS Digital, Civil Registration, Primary Care Mortality Database

Suicide patterns by deprivation

The Index of Multiple Deprivation 2019 (IMD 2019) is an overall measure of multiple deprivation experienced by people living in an area and is calculated for every 32,844 Lower Super Output Areas (LSOA), or neighbourhood, in England. Each LSOA is ranked based on their deprivation scores, with those ranked in the top 10% being considered the most deprived areas in England and those in the bottom 10% the least deprived areas. (Source: The English Indices of Deprivation 2019)

By measuring suicide rates at LSOA level, we can show aggregate rates for each decile or 10% band of deprivation. Figure 11 shows that between 2017 and 2019, suicide rates in the most deprived decile (13.5 per 100,000) are 1.3 times higher than the national average (10.1 per 100,000) and almost 2.5 times higher than in the least deprived decile (5.3 per 100,000). This observed gap shows that 2017-19 suicide rates in the most deprived decile are not statistically significantly different to rates in the least deprived decile.

Figure 11: Directly standardised mortality rates due to suicide in Lincolnshire, by deprivation (IMD 2019), 2017-19 and 2018-20



Source: NHS Digital, Civil Registration, Primary Care Mortality Database

Detailed analysis of deaths from suicide by postcode between 2018 and 2020 reveal clusters of deaths occurring in more deprived areas of Lincolnshire including along the east coast in Mablethorpe and Skegness, in Lincoln and in Boston. It is important to note that whilst suicides have occurred in areas of high deprivation, they also occur in less deprived areas and there does not appear to be any direct correlation.

Between 2018 and 2020, the gap between the most and least deprived deciles in Lincolnshire increased, with suicides in the most deprived decile (18.9 per 100,000) being 3.1 times higher than in the least deprived decile (6.0 per 100,000). The rate in decile 1 is more than double the national average of 9.3 per 100,000. 2018-20 rates in the most deprived decile are significantly higher than those in the least deprived decile.

An Office for National Statistics blog (Source: How does living in a more deprived area influence rates of suicide? 2020) identified that over the past decade, the gap between the most and least deprived areas is only seen among working age people and living in a deprived area increases the risk of suicide, particularly in those aged between their late 30's and late 40's. Middle-aged men, living in the most deprived areas, face even higher risk with suicide rates of up to 36.6 per 100,000 compared to 13.5 per 100,000 in the least deprived areas. It was highlighted that unemployment, economic uncertainty, unmanageable debt, and lack of social connection are all risk factors for suicidal behaviour in men.

Registration delays

Registration delay is the time taken in days between the time of death and the date the death was registered after the Coroner's inquest. For most deaths, the delay is taken as an average, however as deaths from suicide and undetermined intent are often complex and can sometimes take many years for a Coroner to register, this can skew the registration delay. For suicides, the median delay is used, as this is not affected by rare, complex cases.

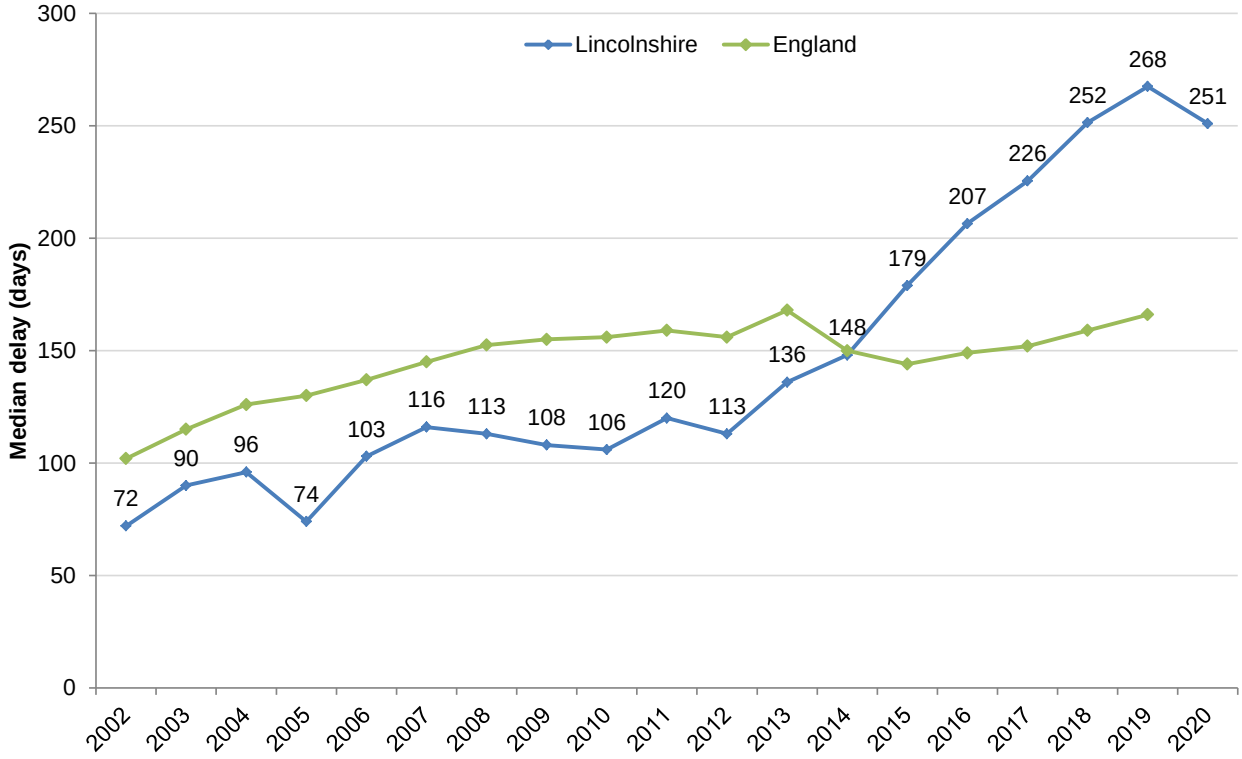
Please note that the latest national data for registration delay is 2019, so no national comparison can be made for 2020.

In Lincolnshire, the median registration delay for suicides registered in 2019 was 268 days, which is 1.5 times higher than the England median of 166 days. Despite a significant upward trend in registration delay in recent years, as well as increased Coroner capacity due to COVID-19, the registration delay for deaths from suicide in 2020 was 251 days, marking the first decline in registration delay since 2012.

Nationally, registration delays were 1.6 times higher in 2019 (166 days) than they were in 2002 (102 days). Lincolnshire has seen a more significant increase in registration delays over the same period, from a median of 72 days in 2002 to 251 days in 2020.

Since 2002, the increase in registration delays in England has been steady, however the increase in Lincolnshire has occurred over a shorter period; the median delay has more than doubled from 127 days in 2011 to 268 in 2019. (Source: ONS Suicides in England and Wales 2019)

Figure 12: Median registration delays due to suicide in Lincolnshire, 2002 - 2020



Source: NHS Digital, Civil Registration, Primary Care Mortality Database; ONS, Suicides in England and Wales 2019

Findings from Lincolnshire Coroner's Service

Prior to 2019, Public Health had created an information sharing agreement with Lincolnshire Coroners Service in which they supplied detailed record level information on all investigated deaths where the Coroners verdict was suicide; or where a verdict of suicide was not reached but where open, narrative, or misadventure verdicts suggested 'undetermined intent' with suicide as a possible cause.

The flow of detailed information stopped in late 2019 as a result of resourcing issues and capacity at the Coroner's Office. Public Health are currently working with the Coroner's Office to resolve the backlog of missing information and re-establish the process of sharing this vital evidence.

Data collection

This summary provides additional context on the deceased, drawn from the more extensive and highly detailed records and case notes associated with the Coroner's investigation, and includes more specific personal details for the deceased, details surrounding the death, any risk factors or details of organisations, services or professionals the deceased were in contact with prior to death.

Lincolnshire Coroner's Service provided data on 116 deaths where inquests concluded a verdict of suicide, open, narrative or misadventure verdicts; this data covers all deaths concluded during 2016, 2017, 2018, and up to February 2019.

Key findings

- Of the 116 suicides concluded, 78% were men.
- 26% of suicides were among people aged between 50 and 59 years, 83% of which were men.
- There were 11 suicides by young people under 25, and 13 suicides by people aged 75 and over.
- There were 16 people who were born outside of the UK (mainly from EU countries), making up 14% of all cases.
- Just over half (51%) were either employed or self-employed at the time of their death.
- The most common method of suicide was hanging, strangulation or suffocation, used in 60% in suicides.
- 70% of suicides occurred in the individual's own home.
- Almost two thirds (65%) of suicides were concluded to have been premeditated, and over half (51%) of people who died left a suicide note.
- 43% had known suicidal tendencies and 40% of those who died by/from suicide had made at least one previous attempt.
- 67% of people who died were known to have experienced some form of mental ill health.

Findings from Real Time Surveillance data

To support wider suicide prevention in line with the strategy and action plan, a suicide Real Time Surveillance (RTS) evaluation project was undertaken between December 2019 and February 2020 to investigate the possibility of establishing permanent data flows between Lincolnshire Police and Lincolnshire Public Health. The information shared by Lincolnshire Police is taken from the Sudden Death Report completed by the attending officer at the incident.

The result of this evaluation found that the information was sufficiently detailed and timely to be used as a possible tool in suicide prevention. It is expected that RTS will help by:

- Developing an early alert system for suicides
- Enabling all appropriate agencies to be more responsive to suicides
- Better identifying any patterns and trends in suicides which could aid prevention by enhancing targeting of services
- Reducing suicide rates

The following summary looks at data reported from January 2019 to December 2020 and provides some context to all deaths where suicide was suspected. Please note following analysis is interpretive of the RTS data only; however it is not conclusive, as these cases are still subject to a Coroner's inquest.

- In 2019, there were 77 deaths where suicide was suspected, and in 2020 there were 73 deaths.
- 83% of deaths in 2019 and 68% in 2020 were males, which is comparable to figures reported from Civil Registration mortality data.
- 22% of suspected suicides in 2019 were in the 50-59 year age groups, and 25% of suspected suicides in 2020 were in the 30-39 year age groups.
- The ages at time of death recorded range from 15 years to 84 years and the average age at death was 47 years in 2019 and 45 years in 2020.
- Hanging/strangulation/suffocation was the most common method, making up 69% of all suspected suicides in 2019 and 51% in 2020. The proportion of suspected suicides from poisoning has increased from 13% in 2019 to 30% in 2020.
- In the remaining cases, drowning, asphyxia, cutting/stabbing, and jumping from height were mentioned in the Sudden Death Report.
- 65% of suspected suicides in 2019 and 63% in 2020 occurred in or around the deceased own home. In the remaining cases, deaths occurred in park/woodland areas, rivers/lakes/canals and railways/roads.

Conclusion

The local picture shows that deaths from suicide in Lincolnshire have increased since the last reported audit; however, these increases are in line with nationally reported figures.

Characteristics and details surrounding suicides remain consistent with previous years, with hanging/strangulation/suffocation being the most common method for people to take their own lives, both in Lincolnshire and nationally.

As with previous audits, men continue to contribute to the majority of suicides in Lincolnshire, however the gender gap had widened in 2019 with men making up 86% of all suicides, and 73% of all suicides in 2020.

Findings from the Coroner's data showed that 78% of deaths from suicide between January 2016 and February 2019 were men. Further analysis revealed that hanging/strangulation/suffocation was the most common method of suicide, 67% of individuals had experienced mental ill health, 43% had known suicidal tendencies, and 40% had made at least one previous attempt.

Findings from the Real Time Surveillance project are consistent with registered mortality and Coroners data, with 83% of suspected suicides in 2019 and 68% in 2020 being men and hanging/strangulation/suffocation made up 69% of all suspected suicides in 2019 and 51% in 2020.

This audit continued to look at suicides using both NHS Digital mortality data to provide long term figures; however due to the Coroner's Office being unable to resource and supply enhanced data, analysis of detailed Coroner's data for 2019 and 2020 was not included. Hence, detailed monitoring of risk factors of deaths from suicide in Lincolnshire was not possible for this report.

The global COVID-19 pandemic has resulted in negative impact on mental health of UK population. This impact has resulted from anxieties about the disease, loneliness and social isolation from extended lockdown and shielding of vulnerable groups, and from anxieties across all members of society about job insecurity, bereavement, and educational attainment. Also, long term effect of COVID-19 infection, particularly among some young people, can lead to long term mental health complications.

In a May 2021 briefing, the Centre for Mental Health have predicted that around 10 million people in the UK (8.5 million adults and 1.5 million children and young people) will require mental health support in the next three to five years as a direct result of the pandemic. The briefing identified that the groups of people who face an especially high risk of poor mental health include people who have survived severe COVID-19 illness (especially those treated in intensive care), those working in health and care services during the pandemic, people economically impacted by the pandemic and those who have been bereaved. (Source: Centre for Mental Health, Covid-19 and the nation's mental health, May 2021).

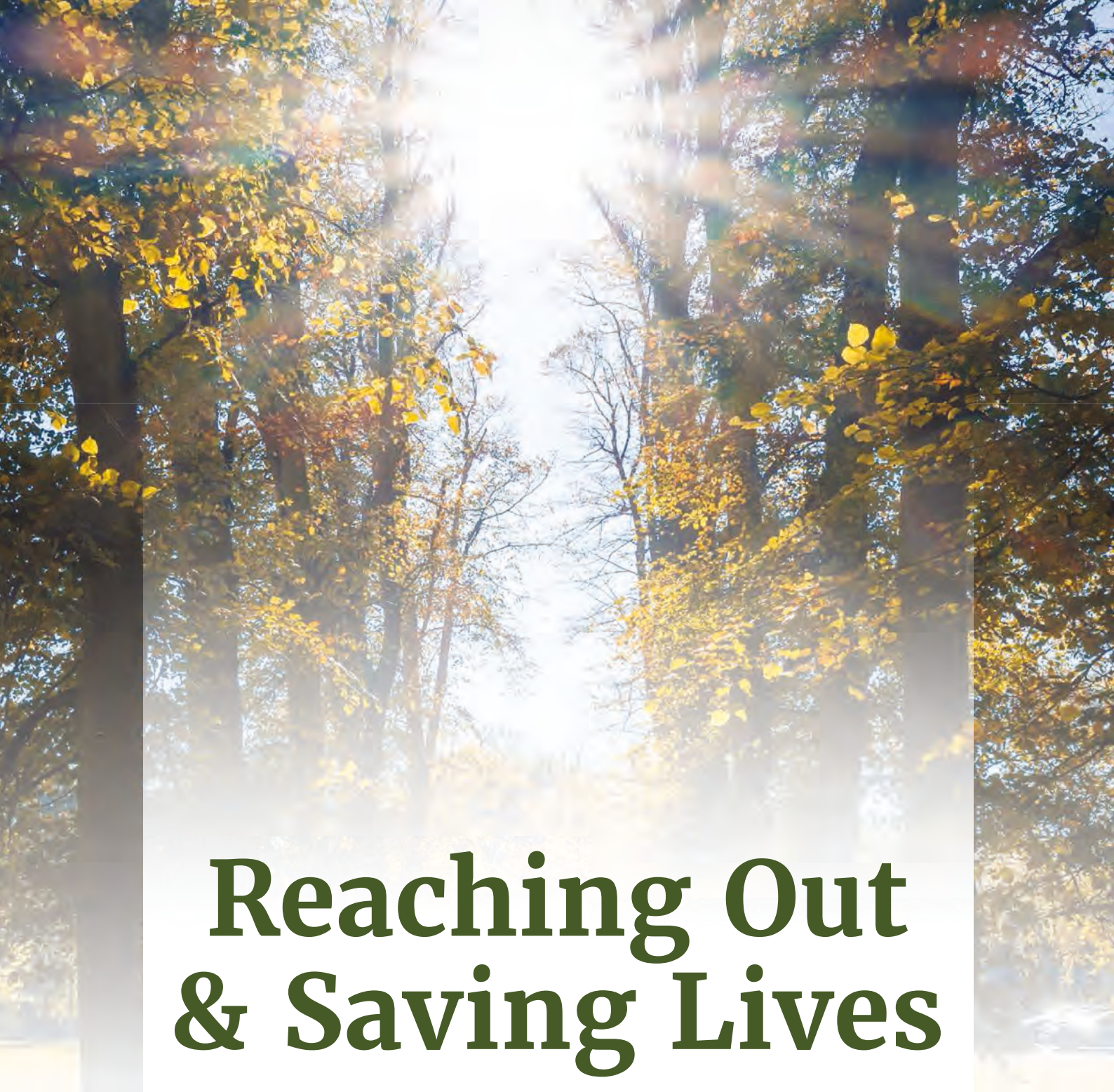
In a follow up to the Mental Health and Young People Survey (MHCYP) in July 2020, one in six (16%) of children aged 5 to 16 had a probable mental health disorder during the pandemic, compared to one in nine (10.8%) in 2017.

In August 2020, the Office for National Statistics (ONS) reported that almost one in five adults (19.2%) were likely to be experiencing some form of depression during the pandemic as at June 2020; this had almost doubled from around 1 in 10 (9.7%) before the pandemic (July 2019 to March 2020).

A NatCen study on older people found that incidence of depression, anxiety and loneliness was greater in those who were in high risk groups and self-isolating, and those with existing co-morbidities.

Recommendations

- Suicide audits should continue to be produced annually, to support the Lincolnshire Suicide Prevention Strategy and Action Plan 2020 - 2023.
- There is a need to be able to access Coroner's records on deaths from suicides in order to understand potential risk factors where targeted actions can reduce the number of deaths from suicide.
- Support the Lincolnshire Suicide Prevention Steering Group in their implementation of the RTS process locally to ensure the information is used effectively to monitor cases and to escalate any new or emerging issues.
- Monitor the impact of the COVID-19 pandemic on population health and wellbeing as new and additional evidence emerges and direct targeted interventions at groups identified as having an increased risk of death from suicide.



Reaching Out & Saving Lives

LINCOLNSHIRE

SUICIDE PREVENTION STRATEGY

2020-2023

Lincolnshire COUNTY COUNCIL

Working for a better future

FOREWORD

Throughout the country deaths from suicide continue to be a major concern, particularly among younger people. Not only does it lead to the needless loss of life, it can have heart-breaking and far-reaching consequences for family, friends and communities.

But suicide isn't always inevitable and it is preventable. We've come together with partners throughout the county to produce a Suicide Prevention Strategy for Lincolnshire which aims to reduce suicide and suicide behaviours to a minimum.

By working in partnership we can take action to address risk factors like self-harm, target prevention of suicide in high risk groups and improve the emotional wellbeing and mental health of children and young people.

All partners are committed to this shared ambition. Suicide prevention will be at the heart all the work we do, directly helping people who contact us for support, with joined up services and a clear pathway where everyone can get the right support at the right time.

Councillor Mrs Patricia Bradwell OBE

Deputy Leader & Executive Councillor for Adult Care, Health and Children's Services,

Lincolnshire County Council

PURPOSE

1. Suicide is a major issue for society and a leading cause of years of life lost. It is the biggest killer of people under the age of 35 and the biggest killer of men under the age of 50. It is a leading cause of death in the UK for 10-19 year olds. These deaths are often the result of the ultimate loss of hope and meaning of purpose in life. Suicide can devastate families and leave a lasting impact on their own wellbeing. However, suicide is not always inevitable and is preventable.
2. The Lincolnshire Suicide Prevention Strategy 2020 – 2023, which has been developed on a multi-agency basis strives to reduce suicide and suicide behaviours in Lincolnshire to a minimum.

This document sets out Lincolnshire's shared vision, mission and priorities. Some organisations in Lincolnshire are required to have, or have chosen to develop their own suicide prevention strategies (for example Lincolnshire Partnership NHS Foundation Trust). All other organisations and partners will have agreed to reference this document in their own strategies as well as provide details on how they will contribute to achieving the shared priorities identified.

EXECUTIVE SUMMARY

1. During 2017-18 on average more than 1 person per week took their own life in Lincolnshire.
2. It is estimated that one in five people consider suicide at some point in their lives.
3. The human cost of death by suicide is high and tends to have an especially heightened and widespread effect for those in the family and beyond. Research suggests that around 135 people may be affected by each person dying by suicide. This can impact on people's ability to work, to continue with caring responsibilities and to have satisfying relationships.
4. National guidance recommends that every Local Authority carries out a suicide audit, develops a suicide prevention action plan, and establishes a multi-agency group to co-ordinate effective action within the local area.
5. In line with this guidance, this strategy has been developed by actively engaging local partnerships through the Suicide Prevention Steering Group and the Lincolnshire Mental Health Crisis Concordat, using local data and intelligence and with reference to regional and national strategies. A multi-agency governance structure has been developed to manage delivery of the strategy and monitor how well it is achieving its objectives.
6. The success of this strategy is dependent upon the vision and resources of partner agencies and within our local communities. It is underpinned by the assumption that more can be delivered by improved coordination of existing services and activities, alongside key stakeholders working to a common vision and plan. Lincolnshire has currently not received any of the National funding available for suicide prevention.
7. The suicide agenda is closely aligned to the Mental Health agenda and the additional national investment in mental health provision, and in particular Mental Health Crisis provision, will play a key role in delivering our local suicide prevention offer.
8. Our vision in Lincolnshire is consistent with the national suicide prevention strategy for England, the outcome of the Lincolnshire Suicide Prevention Summit and the Suicide Prevention strategies of partner agencies, including those of NHS partners, who operate a zero based approach to suicide.

OUR VISION & MISSION

Our Vision and Mission statements as agreed at the Lincolnshire summit meeting are set out below. Lincolnshire is a place where suicide is not considered and people continue to have hope.

Our Vision

Lincolnshire is a place where suicide is not considered as an option and people continue to have hope.

Mission

Reaching out and savings lives.

VALUES

We believe the loss of any life to suicide is a tragedy and therefore we want people to seek help before they consider that suicide is their only option. We want people to have hope that things can get better. We also want people to understand that they can receive help and support through a range of different ways.

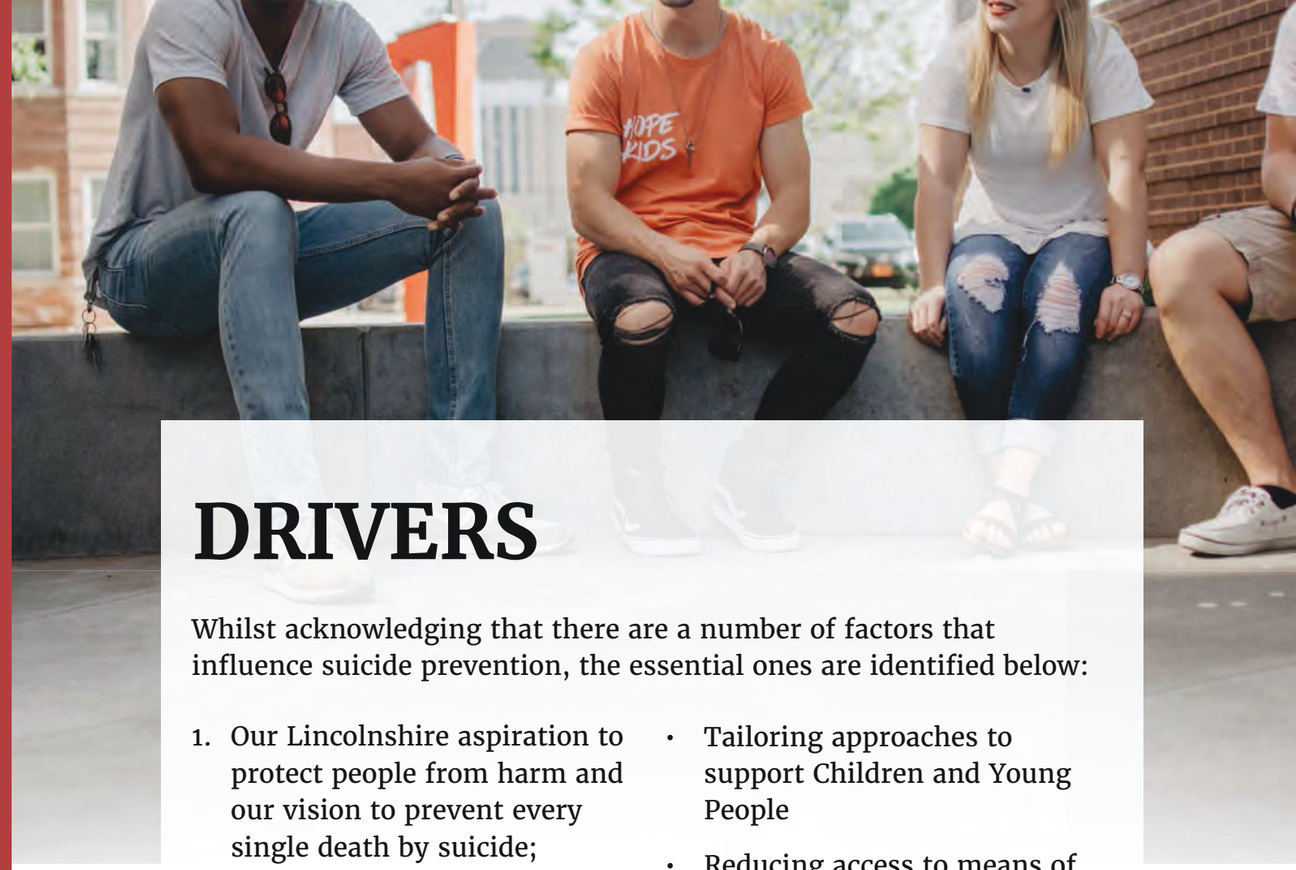
We recognise that people sometimes find it difficult to talk about their feelings and therefore it is important to regularly ask people if they are ok and whether they want to talk anything through. A single discussion may be enough to give someone hope and help them to seek further support.

Many organisations and professionals have a key role in recognising and supporting people with thoughts of suicide and should be supported in this through adequate training and procedures. We also expect that family, friends and carers can regularly ask people how they are and to start a conversation. However it is not necessary to know someone to recognise that they may be worried about something or may be unwell. We would therefore encourage everyone to reach out a hand of kindness, as this simple action could potentially be enough to save a life.

We want everyone to know how best to support someone if they need to talk about how they are feeling, through providing information, advice and signposting. This way everyone can play their part in preventing suicide and is the foundation stone of this strategy.

GOVERNANCE

The Director of Public Health (DPH) is formally responsible for the development of a local Suicide Prevention Strategy and Action Plan through co-production with partners across Lincolnshire. The governance arrangements for the development and implementation of this strategy and action plan, including monitoring performance, lays with Lincolnshire Safeguarding Adults Board (LSAB) and Lincolnshire Safeguarding Children Partnership (LSCP). The DPH will provide assurance to the Lincolnshire Health and Wellbeing Board through the reporting mechanism for the Mental Health (Adults) priority of the **Joint Health and Wellbeing Strategy.** The Suicide Prevention Steering Group (SPSG) will sit under the LSAB and LSCP and will carrying out the tasks within the action plan. Further task and finish groups may form under the SPSG



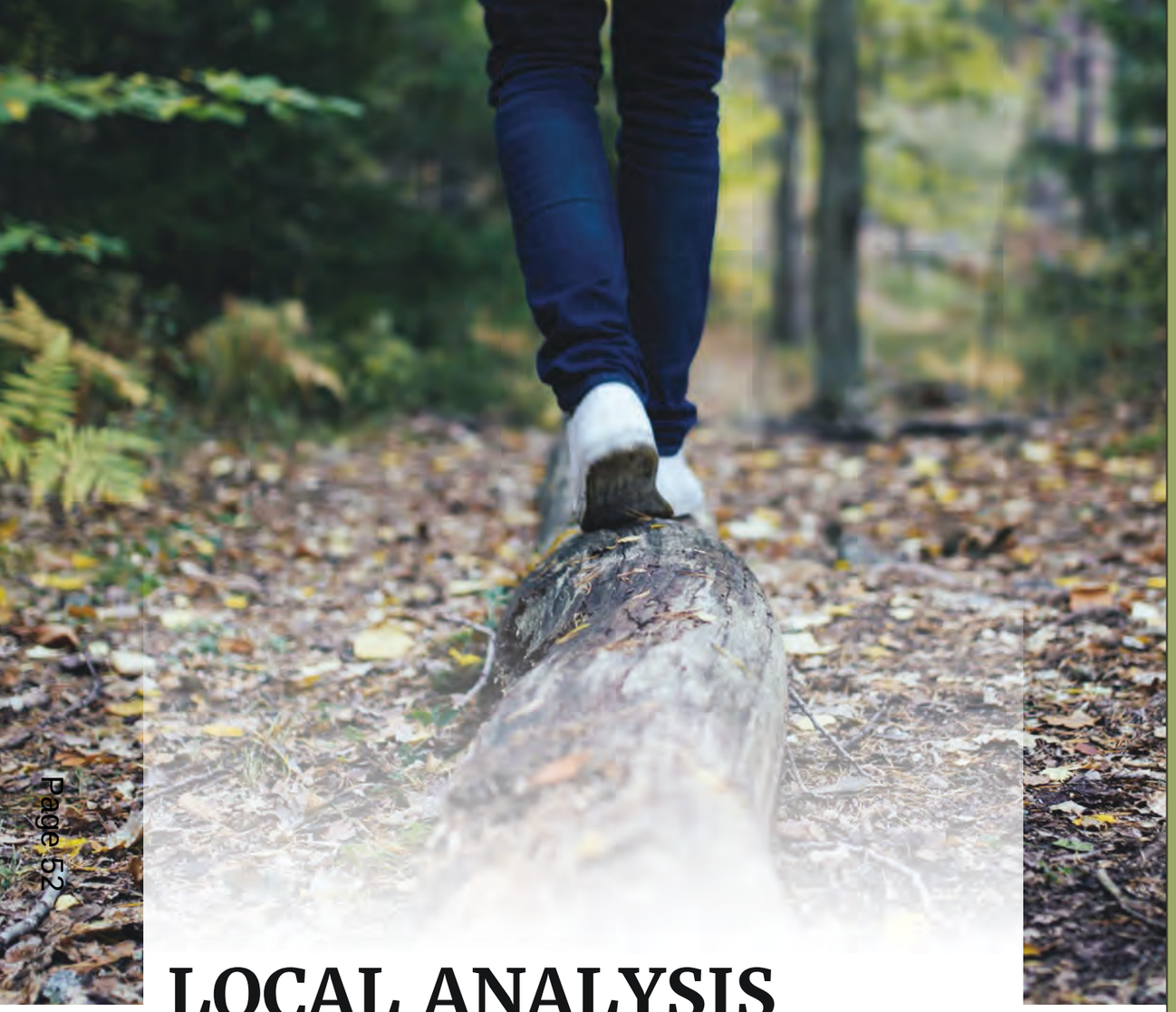
DRIVERS

Whilst acknowledging that there are a number of factors that influence suicide prevention, the essential ones are identified below:

1. Our Lincolnshire aspiration to protect people from harm and our vision to prevent every single death by suicide;
2. The strategy has also been informed by the outcome of the Lincolnshire Suicide Summit which took place in January 2019;
3. The Cross-Government Suicide Prevention Workplan 2019 from the Suicide Prevention Minister, which sets out key priorities to include in local action plans is as follows:

- Reducing suicide in high risk groups
- Tailoring approaches to improve mental health in specific groups
- Tailoring approaches to support Children and Young People
- Reducing access to means of suicide
- Providing better information and support to those bereaved or affected by suicide
- Supporting the media to deliver a sensitive approach to suicide and suicidal behaviour
- Supporting research, data collection and information.

All drivers can be found in the Joint Strategic Needs Assessment Suicide Topic on the Lincolnshire Research Observatory website.



LOCAL ANALYSIS

There is a requirement for Public Health teams to complete an annual suicide audit. As part of these audits, information from the coroner's office is incorporated into the analysis. These audits produce intelligence that helps us to identify cohorts of people who are at high risk of suicide. This intelligence also helps us to consider local priority actions for preventing suicide. The Lincolnshire Annual Audit 2019 identified a number of key statistics and issues as follows:

- There were 85 registered deaths in 2018 due to suicide and undetermined intent in Lincolnshire.
- The 3-year pooled average number of suicides in Lincolnshire have remained the same since 2009.
- 80% of suicides in Lincolnshire were men.
- Suicide rates are highest in people aged 45-49 years, but this varies by gender (55-59, 45-49 and 25-29 years for men, and 75-79, 45-49 and 35-39 years for women).
- The most common methods of suicide are hanging (55.6% of all suicides), followed by poisoning (24%).
- Suicide rates are almost four times higher in the most deprived areas of Lincolnshire, compared to the least deprived areas.
- Lincolnshire Coroners Service provided data on 116 deaths where inquests concluded during 2016, 2017, 2018, and up to February 2019. Of these 116 deaths:
    * 78% were men.
    * The average age of death was 51 years for men and 52 years for women.
    * 14% were born outside of the UK (mainly from EU countries). The average age of death for those born outside the UK was 40 years.
    * 51% were either employed or self-employed at the time of their death. The highest proportion of people who died worked in skilled trade occupations (23%).
    * 70% of suicides occurred in the individual's own home.
    * Mental ill health, known suicidal tendencies, family/relationship issues, previous suicide attempt(s), and substance misuse were identified as some of the key risk factors for recorded suicides in Lincolnshire.

All Lincolnshire Annual Suicide Audits can be found on the Lincolnshire Research Observatory website.

KEY OBJECTIVES

PRIORITIES FOR ACTION

The following priorities for action have been identified from the Lincolnshire Suicide Prevention Summit in 2019, national guidance and feedback from key stakeholders.

The key objectives will be underpinned by the concepts of Prevention, Intervention and Postvention.

- Suicide prevention refers to diminishing the risk of self-inflicted harm with the intent to end life. It may not be possible to remove the risk of suicide completely, but it is possible to reduce this risk. Intentional efforts to reduce the risk (i.e. education), in addition to the presence of natural protective factors (i.e. social support and connectedness), can aid in suicide prevention.
- Suicide intervention refers to a direct effort to prevent someone from intentionally attempting to end their own life.
- Suicide postvention refers to measures occurring after a suicide and attempted suicide has taken place that address the needs of those affected. Postvention can take many forms, but its purpose is to support those affected to cope with the loss, reduce the risk of suicidal behaviour and support healthy recovery in the aftermath of a suicide. Postvention also serves as prevention when it promotes healing of those affected which then can reduce their risk of suicide.

In order to deliver our vision, we have developed the following shared objectives:

1. We will develop a **Local Suicide Prevention Core Offer**. This will confirm what help and support is available to people if they have self-harmed, have experienced suicidal thoughts and those that are bereaved by suicide. It will also set out a pathway of how help and support can be accessed, using a no wrong door approach.
2. We will target **high risk groups**. We will develop our understanding of how best to prevent suicide in high risk groups through research, analysis and engagement with key stakeholders. The Suicide Prevention Steering Group responsible for developing and implementing this strategy will develop specific prevention initiatives to be targeted at these high risk groups.
3. We will support **Children and Young People** (CYP) and their families. We will develop our understanding of how best to reduce suicide and suicidal behaviour in children and young people through research, analysis and engagement with key stakeholders. Using current resources, the key focus will be to promote and improve children and young people's emotional wellbeing and mental health through effective awareness and support to CYP and families from birth right through school to adulthood, as well as improving access to support, creating mentally healthy schools and communities for CYP, targeting promotion and support for the most vulnerable and providing effective crisis support when required.
4. We will develop our **knowledge and intelligence**. A key source of intelligence that has informed this strategy are the annual suicide audits completed by colleagues in Public Health. This will continue to be strengthened with further intelligence to determine the focus of the Suicide Prevention Strategy and Action Plan.
5. We will raise **awareness and improve training**. We will agree a common approach to raising awareness of suicide and of identifying training needs. The Lincolnshire Core Suicide Prevention Offer will include guidance that professionals and the public can access to increase awareness of suicide, associate risks and what they can do to help prevent suicide. Targeted suicide awareness training for community groups as well as professional front line staff will be established and will form an important element of this strategy.

This strategy is supported by the following partners

Lincolnshire's Suicide Prevention Action Plan

A summary of the priority actions relevant to this strategy can be found in the document entitled Lincolnshire's Suicide Prevention Action Plan.

It is our intention to review these priority actions annually following consideration of any national directives, the annual suicide audit intelligence, after reviewing progress against the action plan and any performance against local indicators that we will monitor as part of this strategy.

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Lincolnshire COUNTY COUNCIL Working for a better future		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Open Report on behalf of United Lincolnshire Hospitals NHS Trust

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**16 February 2022**
Subject:	**United Lincolnshire Hospitals NHS Trust – Reconfiguration of Urology Services Update**

Summary:

Since 9 August 2021, United Lincolnshire Hospitals NHS Trust has been operating a reconfigured urology service, whereby Lincoln County Hospital is due to receive all emergency urology admissions seven days per week (instead of both Lincoln and Pilgrim Hospital, as previously). The aim is to better manage elective urology procedures and reduce cancellations, which would in turn increase capacity and support the recovery of services post-Covid-19. This report provides an update on the service since its reconfiguration.

The report concludes that the expected benefits of the model and its wider impact will continue to be monitored, but it is difficult to draw conclusions given the limited amount of data available at this stage.

Actions Requested:

The Health Scrutiny Committee for Lincolnshire is requested to consider this paper as an update of the implementation of the new model for urology in Lincolnshire's hospitals.

1. Background

In early 2021, United Lincolnshire Hospitals NHS Trust (ULHT) highlighted the challenges facing the urology service across Lincolnshire's hospitals, and proposed a public engagement exercise to consult upon proposed changes to these services. The twelve week consultation began on 17 May 2021, and that included a discussion at Health Scrutiny Committee on 23 June and at the ULHT Trust Board on 6 July 2021.

On 3 August 2021, the findings of the consultation were presented to the ULHT Trust Board, and the proposed changes to the urology service approved, to start on 9 August 2022. At this time, there was also a request for a three-month review to ensure benefits were being realised and the project was delivering the expected outcomes.

2. The Model

Whilst previously the urology service within ULHT involved emergency urology patients being admitted to both Lincoln County Hospital and Pilgrim Hospital, Boston, the approved reconfigured model enabled Lincoln County Hospital to receive all emergency urology admissions seven days per week. The aim was to ensure that the other sites were better organised to manage the majority of elective urology procedures, thereby reducing elective cancellations, increasing capacity and supporting the recovery of services post-Covid-19.

Essentially, this approach planned to level the demand across the sites, creating enhanced patient choice and reducing patient wait times, while better meeting the needs of our emergency cases.

Under the current reconfigured model, Pilgrim Hospital continues to see emergency urology patients, but if the patient needs admission or surgery, they are transferred to Lincoln County Hospital if they are medically stable to do so. Where patients are too unstable for transfer, they are admitted to Pilgrim Hospital ICU and the urology consultant on-call will travel to Pilgrim Hospital as required to assess and support with the management of the patient.

3. Case for Change

Historically ULHT had struggled with delivering the optimal mix of capability, capacity and resources for urology across its hospital sites. Services tended to be delivered across all sites, however the rurality of Lincolnshire means that the distance between the sites and poor transport infrastructure limits opportunities for scale and networked ways of working. Over recent years ULHT has experienced pressure on elective beds due to a high volume of unplanned admissions.

Alongside this, prior to the service reconfiguration, high medical vacancies existed across ULHT in the urology (elective and non-elective) service (c.28% of medical posts vacant).

Data analysed between 2017 - 2020 inclusive show that, on average, five urology procedures were cancelled every day (c.1,900 annually). For the procedures that were cancelled by the hospital (i.e. not by the patient), around 25% were cancelled on the day and 10% due to lack of beds. Cancellation of surgery at any time leads to poor patient experience and satisfaction, and additional pressure on the waiting list. A cancellation on the day of surgery is extremely distressing for patients and their families.

The NHS Long Term Plan published on 7 January 2019 fully supports the split of elective and non-elective work onto different sites to drive improvements, and recognises that managing complex, urgent care on a separate dedicated site allows improved emergency assessment and better access to specialist care, so patients have better access to the right expertise at the right time.

On the basis of recommendations arising from the Urology Getting It Right First Time (GIRFT) visit, urology was selected for a major reconfiguration supported by the Integrated Improvement Directorate (IID) Delivery Team and KPMG, with strong executive sponsorship.

The GIRFT programme's national report into urology services, published in 2018, made a number of important recommendations around the delivery of emergency urological care. These include providing consultant delivered emergency care by reducing elective commitments when on call, reviewing workloads to ensure on-call arrangements are sustainable, and focusing available resources to ensure high-quality emergency care is available seven days a week. Most NHS organisations ensure that consultants are not on-call when delivering elective commitments to ensure prompt response to emergency care.

The current reconfigured model for urology services at ULHT was developed following an options appraisal with GIRFT clinical lead, Mr Simon Harrison, and supports the delivery of these recommendations. Support has been provided by the regional GIRFT implementation team throughout the project, through weekly meetings with the project team, and the current reconfigured model was presented to the GIRFT clinical leads on 23 July 2021. The team offered uniform support for the model.

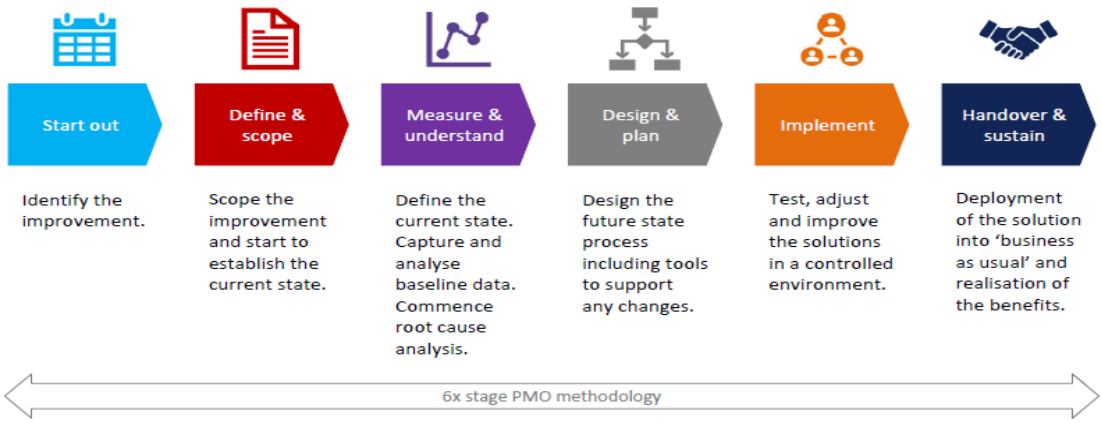
The key features of the reconfiguration include:

- Focus for acute urology at a single site emphasising increased same day care, acute lists and clinics
- Maintenance of diagnostic and outpatient activity across sites
- Increased non-complex elective procedures at Grantham and Pilgrim, with a focus on day case and short stay work but including specialist stone procedures.
- Retaining some complex major procedures at Lincoln County Hospital
- Single urology team with expanded consultant and SAS (specialty and associate specialist) doctors and a new tier of acute care practitioners. (ACPs)

Additionally, the project outcomes link directly to the Trust's 5 year Integrated Improvement Plan. At high level, the alignment to each of the strategy themes is as follows:

Patients	• Complaints, SI's and DATIX • Average length of stay (emergency) • Cancelled procedures • Cancer Performance (28 day) • Variation in cost per patient (Person Level Information and Costing Systems) • Procurement costs
People	• Staff engagement and medical vacancy rates
Service	• Financial performance • Agency costs • Service stability
Partners	• Collaboration with GIRFT – best practice alignment and delivery of GIRFT recommendations.

Delivery of the urology reconfiguration has been managed using the existing 6x stage project methodology with additional elements added to align with the Outstanding Care Improvement System (OCIS).



4. Benefits Realised to Date

Since go-live of the reconfigured service on 9 August 2021, the following benefits have been noted. More detail in these is available later in this report:

Benefit Theme	Progress to Date	Current Status
Deliver the change	Service now reconfigured following formal patient consultation. Service go-live 9 August 2021.	
Admissions	Total number of non-elective admissions downward trend since go-live. Ongoing monitoring of this metric in place.	

Benefit Theme	Progress to Date	Current Status
Voice of the Patient	Mechanism in place to capture feedback specifically on the reconfiguration. Overall, positive themes emerging from the feedback	
Staff engagement	Robust baselining of engagement taken pre-go live and also 3 months post go live. Opportunities exist to improve engagement. Action plan to be created based on the latest feedback.	
Staff vacancy rate	Medical vacancy rate now at 0 (compared to 28% before the reconfiguration.)	
Financial performance	The total investment into the service is £700k pa. Medical agency spend reduced to zero. To date, the overall pay savings reported amount to £9.4k, and this is expected to increase to up to £140k in this financial year now that medical agency has fully ceased.	
Collaboration with GIRFT	Endorsement of changes via the GIRFT clinical leads.	

A number of stakeholder experts have been involved throughout implementation of the new model, they are:

- GIRFT (Get it Right First Time)
- Patient Experience panel
- KPMG
- East Midlands Ambulance Service
- Lincolnshire Clinical Commissioning Group
- United Lincolnshire Hospitals NHS Trust Staff

In the original evaluation of the new reconfigured model, it was recommended that the trust adopts a reporting dashboard to track delivery of the key expected benefits, monitor desirable/undesirable impacts and drive performance improvements in terms of quality, safety, patient experience and use of resources.

These criteria were fully defined in the original Project Charter for the reconfiguration. This dashboard has now been created, therefore, performance against the KPI's is regularly monitored and performance against these are highlighted below in 'Benefits Matrix'. The dashboard aligns with the 'scorecard principle' adopted by the wider Outstanding Care Improvement System (OCIS).

	Expected Benefit Areas
Services	Medical agency spend reduction Procurement cost opportunities Reduction in service deficit against budget Sustainable financial service Urology assessment unit Improved flow from the Emergency Department

People	Improved engagement Training opportunity for SAS & ACP tier Reduced admin burden to manage rota and resource
Patients	Complaints, SIs and DATIX reductions Average length of stay reduction Direct access model for cancer pathway Continuity and consistency of care Increase in proportion of patients discharged from assessment unit Improved flow from Emergency Department Reduced waiting list and pathway times for cancer and Referral to Treatment Reduced cancellations on the day Reduction in non-elective admissions and overall bed usage
Partner	Alignment of solution with GIRFT recommendations and best practice guidance Increased support of Primary Care Work with system to provide best care for Lincolnshire patients

Benefits Matrix

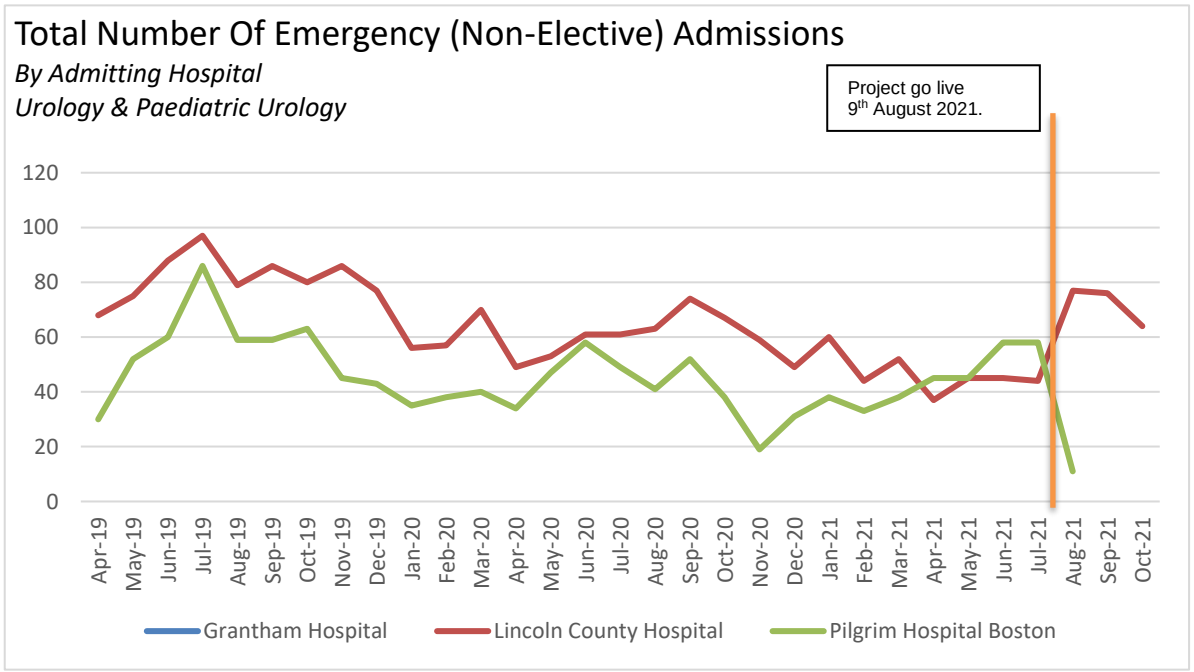
A comprehensive benefits matrix has been captured to support the reconfiguration. Below is a summary of the benefits matrix that continues to be used to manage and track the benefits of the reconfiguration.

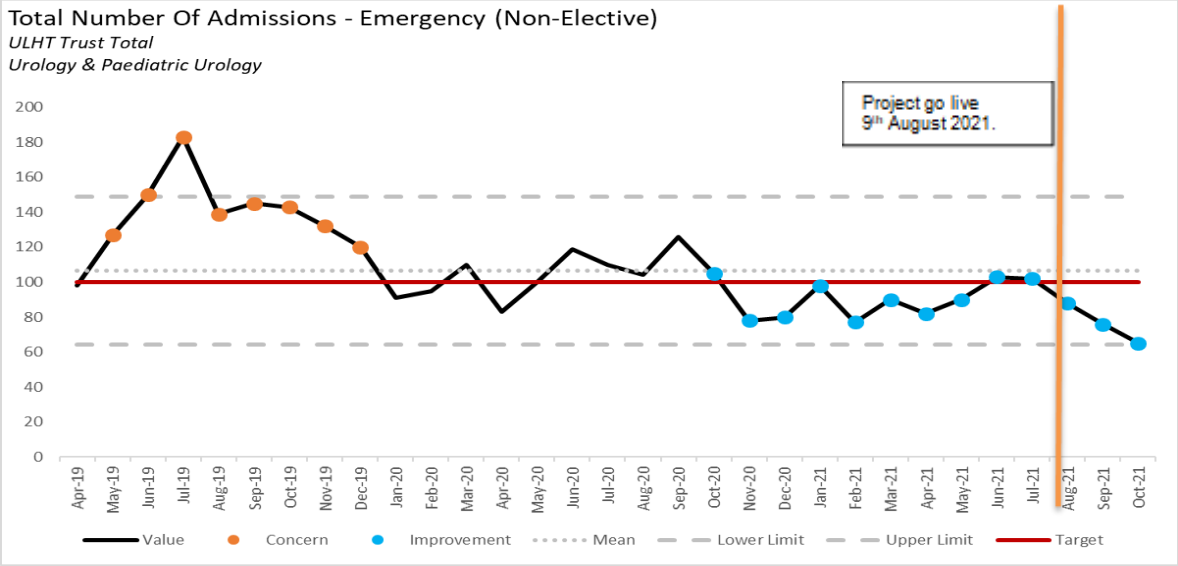
Benefit	Baseline	Opportunity statement	Current performance – NOV 2021	Current status	Quality	Operations	Workforce	Finance	GIRFT	Model Hospital	Benefit Realisation Period from go-live (May-21)
Medical agency spend	£100k / month	• c£300k annually • Reduce to zero by Sept-21	£0 spend on medical agency spend. All spend removed from early November 2021			X	X	X			Phase 1
Average length of stay	3 days	• Root cause understanding of ALoS metrics. Seeking to reduce non-elective admissions and overall bed usage • Increase in proportion of patients discharged from assessment units	Average length of stay remains the same but this is impacted by increased numbers of patients needing packages of care in order to be discharged.		X	X			X	X	Phase 2
Cancelled procedures	13% of EL and DC cases cancelled on same day.	• Reduction in cancelled operations. Target to be established once root cause and analysis completed. • 2019 baseline used – cancelled by the hospital (not patient)	August 13 September 24 October 13. Increase owing to level 4 pressure		X	X	X		X		Phase 2
Cancer performance (28d)	46%	• Direct access pathway model to reduce pathway duration • Improvement in 28d national standard performance • Standardise process • Focus on bladder and kidney pathway	50% Delay in implementing rapid diagnostic pathways due to governance sign off Issues owing to level 4 pressure		X	X					Phase 2
Indirect and PLICS data variation	Various	• Over the data, the total costs for all codes is £13.98m against an income of £11.10m yielding a delta of £2.88m • 80% of the loss (£2.3m) is attributed to 18 unique HRG codes (this accounts for 51% of the total volume of procedures)	Ongoing work being undertaken. Deep drive into areas of the specialty being undertaken which has identified potential for cost reduction per patient.		X	X	X	X	X	X	Phase 2
Procurement costs	£843k annual non pay costs.	• Note: £561k of the total non-pay costs relate to clinical supplies & services • At least £93k identify to date (urethroscope)	Delays in endourology procurement due to staffing issues with Procurement team		X			X			Phase 2

Benefit	Baseline	Opportunity statement	Current performance – NOV 2021	Current status	Quality	Operations	Workforce	Finance	GIRFT	Model Hospital	Benefit Realisation Period
Waiting list	December 2020	• 18 week RTT for ULHT is 60.8% (847 patients over 18 weeks) • Target to be identified following further investigation	• 18 week for RTT 64.44% (889 patients over 18 weeks Position expected to be higher but impact seen from level 4 escalations		X	X		X			Phase 2
Staff engagement	TBC	• Pulse survey issued Jan-21 to establish baseline. • Engagement plan to be developed to support outcomes	• Pulse Survey • Survey to be repeated in March 2022 owing to low responses			X	X		X		Phase 1
On-call provision	GIRFT	• Hot / cold site configuration will address the key concerns from GIRFT about reducing elective commitments for on-call consultants.	• Consultants no longer have elective commitments when undertaking on call		X	X	X	X	X		Phase 1
Emergency care provision	GIRFT	• Ensure high-quality emergency care is available 7-days a week • Explore options as part of a Urology Area Network (UAN)	• Emergency care is delivered on a 3 tier on call system 24/7 • Working in alliance with Leicester		X	X			X		Phase 2
Data integrity	GIRFT	• Review data collection • Improve coding accuracy • Increase income through accurate coding • Staffing costs per WAU	• This is ongoing with the support of Coding and Urology Clinical Leads		X	X	X	X	X	X	Phase 2

Non-Elective Performance

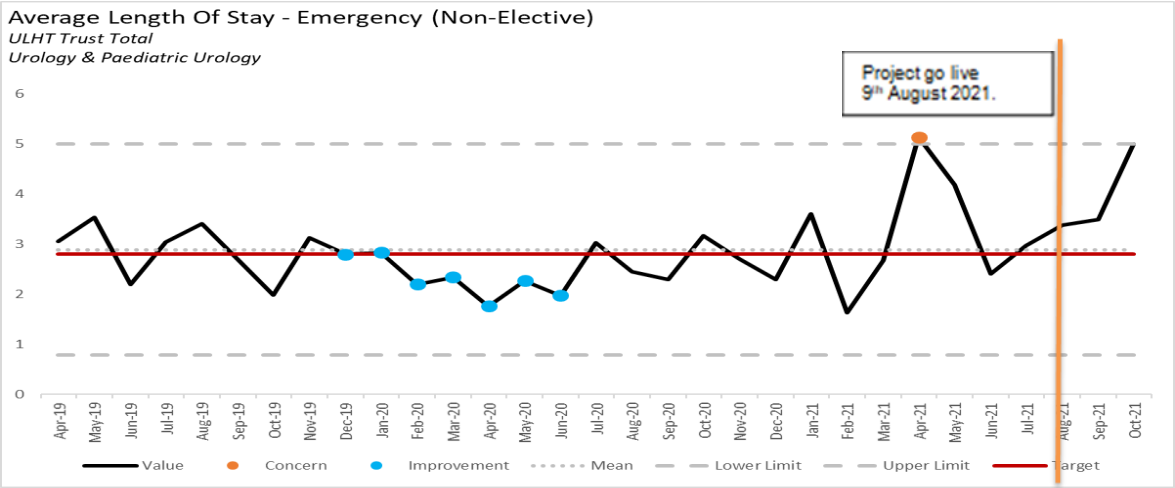
There was concern prior to the re-configuration that non-elective admissions would increase. The reconfigured service went live on the 9 August 2021. As you will see from the graphs below, admissions increased at Lincoln County Hospital once the reconfiguration commenced but are now significantly lower than what they were Trust-wide pre re-configuration. This trend will continue to be monitored through the scorecard.





Average Length of Stay Non-Elective

Average length of stay on the urology non-elective pathway has increased, as have all other specialties within ULHT. However, once the urology patients can all be placed on one ward (level 4 escalation permitting) the specialty is confident this will improve as we can then implement criteria-led discharge.



Quality Impact Assessment

The clinical risk analysis has directly fed into the Quality Impact Assessment (QIA). The QIA was signed off by the Trust's QIA Panel on 12 July 2021. A further update QIA and scorecard was presented on 17 November 2021 which received full support and final sign off. The QIA received high praise from the panel and commented that the level of detail and due diligence that has gone into the document is outstanding.

Patient Feedback

In order to capture patient experience information post go-live, the Project Team set up a Patient Experience Survey for Urology patients. This has been disseminated throughout the service for patients fit to sit and for inpatients. Staff have been encouraged to support patients with providing feedback through this forum. To date, as at 9/11/21, uptake has been three responses (one response from a patient who travelled from Pilgrim Hospital, Boston). It is work in progress given the current climate and winter pressures. Feedback shown below –

> *"The service was excellent; every stage of the procedure was explained thoroughly before proceeding"*
>
> *"The Urologist I saw today, I have seen before, very polite and knowledgeable"*
>
> *"The two paramedics on the ambulance were as efficient and attentive as the staff in the hospital. The staff in the hospital are magnificent under the conditions they work under, short staffed etc"*

Although patient survey responses have been low, no negative feedback via PALS or formal complaints have been raised.

Public/Patient Engagement

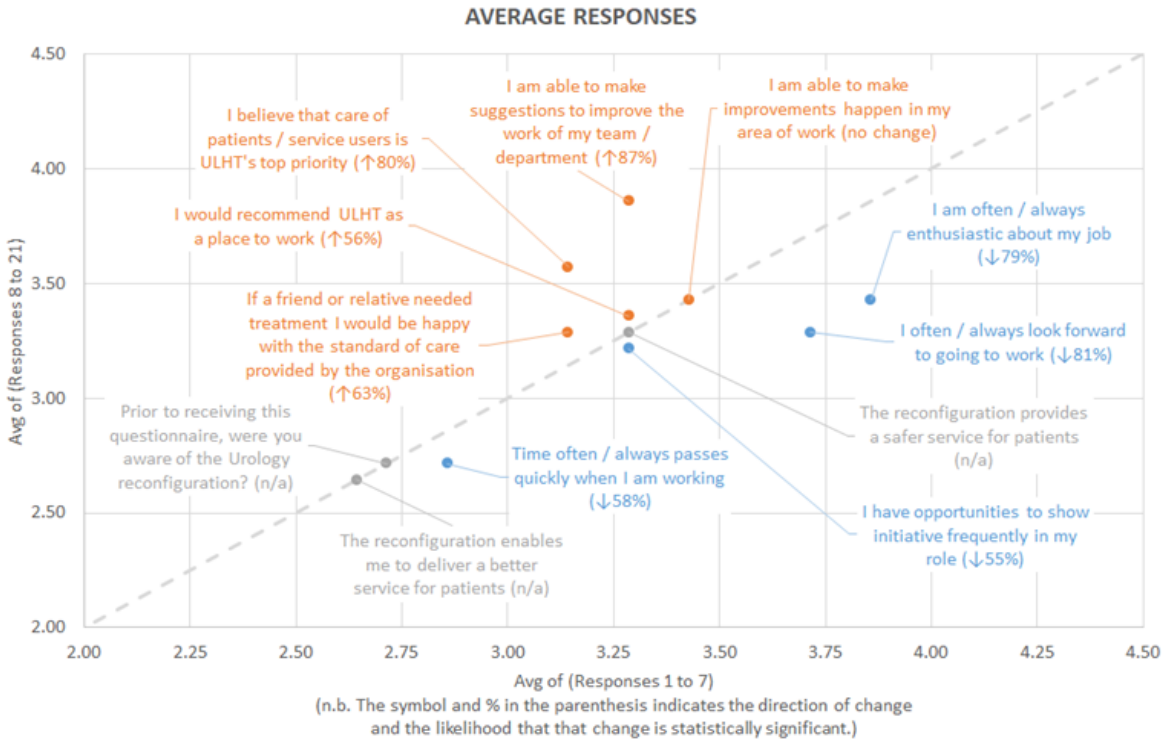
Prior to implementing the reconfiguration, we consulted with Lincolnshire patients over a twelve week period. This involved formal communications about the changes, focus group meetings with patients, clinicians and service leadership for patients to share their views about the proposed changes and to directly influence the reconfiguration model.

Positive Feedback	Concerns	Mitigation
Staff: complimentary about current staff, see the change as a vehicle to improved recruitment and specialists. Resource usage: general feeling that reconfiguration will positively improve access to resources / service. Patient experience: support for the separation of elective and planned activity. Feel this would result in a reduction in	Travel & transport: concern about delays in treatment due to emergency transport to another hospital site. concerns about how Boston-area patients would get back home after discharge from Lincoln hospital. Impact on other providers: EMAS ability to cope with demand.	Hospital transport on discharge will be provided for qualifying patients; for other patients, solutions including taxi provision will be explored on an ad hoc basis. EMAS are in full support of the proposal; modelling suggests the impact will be one additional transfer for admission per day

Positive Feedback	Concerns	Mitigation
cancellations of elective activity. Support a reduction in elective waiting times. Patients happy to travel for expert care. Activity: welcome increased elective activity at Pilgrim, Grantham and Louth hospitals	Patient safety: concern about risks connected with not receiving emergency care as quickly. Concerns about services being moved away from Pilgrim- disadvantaging population of Boston and the East Coast	The additional tier of on call provides enhanced access to specialist opinion through the SPOC. The provision of elective, diagnostic and specialist services at Pilgrim Hospital Boston will increase.

Staff Engagement

Staff were consulted via a questionnaire at the commencement of the project in order to obtain a baseline set of information in relation to staff satisfaction. The questionnaire has now been repeated post go-live in order to identify improvement or otherwise. Approximately 50 staff were consulted, and the response rate has been low. Analysis shown below.



For each question it is possible to compare our score from our first set of surveys (responses 1 to 7) to our score from our second set of surveys (responses 8 to 21), and say (mathematically) whether that score has remained the same, gone up, or gone down.

The responses shown in orange show an increase in positive responses to the questions, those in grey show a remaining consensus and those in blue show an increase in negative response.

The arrow and % at the end of the scatter chart points labels tell us first the direction of travel (the arrow; the text “no change”, an up-arrow, or a down-arrow) and how confident (the % calculated using a statistical test) we can be that the arrow is a true assessment of any change, rather than being simply due to random variation.

It is clear from the responses above that there is more work to be undertaken on improving ‘morale’ of our workforce, however, a higher sample of response would enable us to pin point any high levels of concern.

We plan to undertake a further survey in March 2022 and the in meantime are working with Organisational Development on improving team morale.

5. Finance

Prior to implementation there was a high reliance on agency medics. The investment into this service and improvements to the model of working was expected to improve recruitment and retention of staff. This included:

- Investment of 7.00 whole time equivalent Advanced Clinical Practitioners (ACP), who form part of the first on-call and reduce reliance on agency locums.

- Drive on substantive recruitment of medical staff, including an investment of budget from within the CBU to fund a 10th consultant post.

- Introduction of Core Trainees working across urology and orthopaedics at Grantham site, funded from within the clinical business unit.

The total investment into the service is £700k pa. Spend on medical agency was £780k in 19/20 and £1,153k in 20/21.

	Current Establishment			Future Establishment	
Cost Category	WTE	Cost 19/20 £k	Cost 20/21 £k	WTE	Cost £k
Consultants	8.00	2,143	2,313	10.00	1,682
SAS	8.80	948	992	8.00	878
Specialist Trainee	1.00	119	99	1.00	81
Junior Drs	7.00	325	358	8.00	373
ACPs	-	-	-	6.00	470
Total	24.80	3,535	3,762	33.00	3,484

Table showing current vs future costs of the medical workforce plus the ACPs. The future cost represents the model fully established with post-holders at 'top of scale' and without any premium costs from agency or extra duties.

As a result of these investments and the subsequent elimination of agency the specialty is expected to achieve a cost improvement of c£300k (full year equivalent).

As at October 2021, all posts are either filled or have a plan in place for a new staff member to join, and as such the agency has ceased as planned in early November. The 21/22 medical agency spend year to date is £300k.

To date, the overall pay savings reported amount to £9.4k, and this is expected to increase to up to £140k in this financial year now that medical agency has fully ceased.

The overall capacity and activity will stay the same with the reconfiguration. However, there is a potential income opportunity for reduced cancellations. Of approximately 500 cancelled operations per year, 17% were due to bed availability or unplanned surgeon absence. The reconfiguration could mitigate cancellations for these reasons and therefore there is an opportunity worth around £120k, using an average elective tariff. The expected benefit has not yet been quantified and thus far no benefit realised in relation to reduced cancellations.

Work continues on deep dives into cost variations using patient level cost information, with Finance working with the clinical business unit to identify opportunities for cost savings.

6. Key Risks/Issues

There are a number of potential issues to the continued success of the programme, which are listed below –

Issues							
Description	**Date Raised**	**Status**	**Owner**	**High Level Actions**	**Scoring**	**Impact**	**Latest Review**
Retention of Middle Grade Doctors	21/10/21	Open	Chloe Scruton	Working ongoing with HR to develop an individual development and training structure for each Middle Grade Doctor. Ongoing regular meetings with SAS doctors	2 (Low)	The impact is: We may not be able to fulfil the obligations of the rota in its entirety and may have to utilise agency staff De-stabilisation of service.	4/11/21
Compliance with the new service model by clinical staff – **all** urology patients being directed to LCH, without prior USPOC contact and agreement	19/8/21	Open	Chloe Scruton	Completion of statement of purpose to incorporate roles and responsibilities model – this will then become and official Trust document and communicated accordingly and will ensure absolute clarity in terms of all aspects of the service model for non-elective walk-ins at non-receiving sites (statement of purpose in final draft for the clinical business unit to verify and sign off). Good feedback from staff saying the service is much better. Keeping under review.	2 (Low)	The impact is: The flow of the patient pathway, and therefore the patient experience, may be compromised if the correct process is not followed, causing potential delay and inconvenience to our patients. Additional pressure on Lincoln County Hospital to accommodate non-urgent urology patients, sent in by Pilgrim, that should be seen and treated as usual within A&E.	4/11/21

Issues							
Description	**Date Raised**	**Status**	**Owner**	**High Level Actions**	**Scoring**	**Impact**	**Latest Review**
Establishment of Urology/Trauma Assessment Hub (UTAH) – delayed partly owing to the stand down of CRIG halting progression	16/9/21	Open	Chloe Scruton	Target was to open the UTAH during October 2021. Surgical assessment unit is being used as an interim measure. The business side of the report has been completed and this is now sat with nursing to complete their part. The stand down of CRIG has halted progress. Continuation of use of surgical assessment unit will need to continue. Action: seek acknowledgement from Project Sponsor of the delay with regard to this element of the reconfiguration and to potentially identify a solution to aid progression as quickly as possible Update: Excessive ambulance handover delays have highlighted the need to escalate the establishment of UTAH as part of the solution to remedy some relief on A&E. All money has been approved for estates. Nursing to addressed at CRIG early November. Potential start Jan 2022.	2 (Low)	The establishment of the UTAH is essential to ensuring improved patient flow and timely treatment in the right location. The status quo of using the surgical assessment unit will need to be maintained.	4/11/21

7. Conclusion and Next Steps

Expected benefits of the model and its wider impact are being monitored; however, it is difficult to draw conclusions given the limited amount of data available.

As expected, the medical agency doctor spend has reduced and it is anticipated that this trend will continue. Other metrics have been impacted by the significant urgent and emergency

care pressures that the Trust has experienced in recent months. The team intends to continue to monitor the data to determine any trends over a longer time period.

To ensure performance recovers and remains on track the urology department, along with Information Services, have implemented a dedicated dashboard (contained within the QIA in section 6) tracking key expected benefits. The aim is that this dashboard can be reviewed in real time to assess performance and give the CBU triumvirate team the ability to identify issues and rectify.

Additionally, a thorough lesson learned exercise has been carried out by the project team to ensure knowledge transfer is shared across the Trust.

- Implementation of Urology and Trauma & Orthopaedics Hub
- Recovery of Urology elective RTT and cancer KPI's in order to achieve target performance. Using C2-AI to ensure patients are treated in clinical priority order to optimise patient outcomes
- Ensure improved efforts to gain regular patient and staff feedback
- Present the current model, success and challenges at the Urology GIRFT gateway review in early 2022
- Implement criteria led discharge

The Trust Board of ULHT considered a paper which reviewed the service change to date (as above) on 7 December 2021, and agreed the continuation of the current model, based on the expected benefits of this model.

8. Consultation

This is not a consultation item.

9. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

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Lincolnshire COUNTY COUNCIL Working for a better future		**THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Open Report on behalf of Andrew Crookham
Executive Director - Resources

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**16 February 2022**
Subject:	**Health Scrutiny Committee for Lincolnshire - Work Programme**

Summary

This report sets out the Committee's work programme, and includes items listed for forthcoming meetings, together with other items, which are due to be programmed. The Committee is required to consider whether any further items should be considered for addition to or removal from the work programme.

Actions Required

To consider and comment on the Committee's work programme.

1. Background

At each meeting, the Committee is given an opportunity to review its forthcoming work programme. Typically, at each meeting three to four substantive items are considered, although fewer items may be considered if they are substantial in content.

2. Today's Work Programme

The items listed for today's meeting are set out below: -

16 February 2022		
	Item	*Contributor*
1	East Midlands Ambulance Service Update	East Midlands Ambulance Service Representatives: Ben Holdaway, Director of Operations and Sue Cousland, Divisional Director for Lincolnshire
2	NHS Continuing Healthcare	Wendy Martin, Associate Director of Nursing and Quality, Lincolnshire Clinical Commissioning Group
3	Suicide Prevention In Lincolnshire	Lucy Gavens, Consultant in Public Health, Public Health Division, Lincolnshire County Council
4	United Lincolnshire Hospitals NHS Trust – Urology Services	Representatives from United Lincolnshire Hospitals NHS Trust: Dr Colin Farquharson, Medical Director, and Mr Andrew Simpson, Consultant Urologist

3. Future Work Programme

16 March 2022		
	Item	*Contributor*
1	Community Pain Management Service (CPMS) Update	Representatives from Lincolnshire Clinical Commissioning Group
2	Lincolnshire Pharmaceutical Needs Assessment – Consideration of Consultation Draft	Shabana Edinboro, Senior Public Health Officer, Lincolnshire County Council
3	Lakeside Medical Practice Stamford – Update on Response to the Inspection Report	Lincolnshire Clinical Commissioning Group Representatives: • Wendy Martin, Associate Director of Nursing and Quality • Nick Blake, Head of Transformation and Delivery (South Locality)
4	Quality Accounts 2021-22 – Arrangements for Making Responses	Simon Evans, Health Scrutiny Officer

13 April 2022		
	Item	*Contributor*
1	GP Services Access Update	Dr Kieran Sharrock, Medical Director Lincolnshire Local Medical Committee
2	Mental Health Update from Lincolnshire Partnership NHS Foundation Trust	Sarah Connery, Chief Executive, or Jane Marshall, Director of Strategy, People and Partnership, Lincolnshire Partnership NHS Foundation Trust

18 May 2022		
	Item	*Contributor*
1	Dental Services Update	Representatives from NHS England
2	Cancer Care Update (or 15 June)	Lincolnshire Clinical Commissioning Group: • Clair Raybold, Chief Operating Officer (South West Locality) and Senior Responsible Officer • Louise Jeanes, Programme Lead Cancer Care United Lincolnshire Hospitals NHS Trust: • Colin Farquharson, Medical Director

15 June 2022		
	Item	*Contributor*
1		

13 July 2022		
	Item	*Contributor*
1		

14 September 2022		
	Item	*Contributor*
1	Sustainability Transformation Partnership Clinical Care Portal Data Sharing - Update	Lincolnshire County Council (Adult Care and Community Wellbeing) Representatives: • Theo Jarratt, Head of Quality and Information • Samantha Francis, Information and Systems Manager Representative from United Lincolnshire Hospitals NHS Trust
2	Lincolnshire Pharmaceutical Needs Assessment – Consideration of Final Draft	Shabana Edinboro, Senior Public Health Officer, Lincolnshire County Council

Items to be Programmed

The following items are due to be programmed at forthcoming meetings:

- **Care Quality Commission Report: Protect, Respect, Connect – Decisions about Living and Dying Well During the Covid-19 Pandemic** – On 18 March 2021, the Care Quality Commission published its report, with eleven recommendations, three of which were directed at NHS providers.
- **Staffing Challenges in Hospitals and NHS Lincolnshire People Plan –** On 21 July 2021 the Committee requested inclusion of an item on staffing, particularly at Grantham and District Hospital.
- **Future Commissioning Arrangements for Dental Services, Ophthalmology and Pharmaceutical Services** – The commissioning of these services is due to transfer to Lincolnshire Clinical Commissioning Group in shadow form from April 2022.
- **Nuclear Medicine** – On 15 September 2021, United Lincolnshire Hospitals NHS Trust gave an introductory presentation on the challenges being experienced by its nuclear medicine service and agreed to bring forward proposals to the Committee on potential changes to the service.

4. **Background Papers -** No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Simon Evans, Health Scrutiny Officer, who can be contacted on 07717 868930 or by e-mail at Simon.Evans@lincolnshire.gov.uk